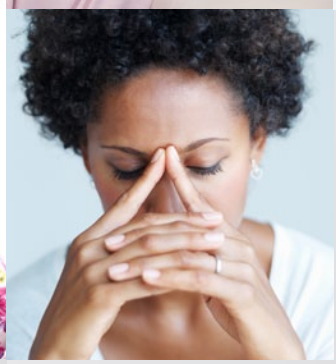







A COMPREHENSIVE APPROACH FOR COMMUNITY-BASED PROGRAMS TO ADDRESS INTIMATE PARTNER VIOLENCE AND PERINATAL DEPRESSION

JANUARY 2013

U.S. Department of Health and Human Services
Health Resources and Services Administration

The publication was produced for the U.S. Department of Health and Human Services, Health Resources and Services Administration by Social Solutions International, Inc. under contract number HRS38370.

This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

Suggested Citation: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *A Comprehensive Approach for Community-Based Programs to Address Intimate Partner Violence and Perinatal Depression*. Rockville, Maryland: U.S. Department of Health and Human Services, 2013.

Preface

The Health Resources and Services Administration (HRSA) Maternal Child Health Bureau's (MCHB) mission is to provide leadership, in partnership with key stakeholders, to promote, protect and improve the physical and mental health, safety and well-being of women, children and their families across the nation. To support this mission, HRSA/MCHB led an initiative called "The State and Community Intimate Partner Violence and Postpartum Depression Resource Development Project." The purpose of the initiative was to collaborate with key stakeholders such as State Title V and Healthy Start Programs to develop resources which would assist state and community-based programs with their efforts to address intimate partner violence and perinatal depression concurrently and improve the assessment, diagnosis and referral of women to services.

Behavioral health affects every mother's personal well-being, parenting abilities, and interpersonal relationships. Equally important and directly related to the mental health of each mother and child is a life free of violence, including intimate partner violence (IPV). The co-morbidities of IPV and Postpartum Depression (PPD) affect pregnant women and their families, sometimes with extreme and/or preventable adverse outcomes. Although public awareness has increased regarding the adverse maternal and child health outcomes associated with the intersection of maternal depression and intimate partner violence, many pregnant and postpartum women with depression who experience IPV remain unidentified by health care providers and consequently do not receive necessary interventions.

Understanding the impact depression and intimate partner violence has on the well-being of families, specifically women before, during, after and beyond pregnancy the initiative changed its focus from postpartum to perinatal health. Through the collaborative nature of the State and Community IPV/PD Resource Development Project, this toolkit was produced along with a series of webinars to supplement the toolkit.

TABLE OF CONTENTS

Introduction 5

How to Use this Toolkit 6

Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression 8

Table 1. U.S. Rates of Intimate Partner Violence Among Females Aged 12-64, by Age, 2001–2005. 13

Table 2. U.S. Rates of Intimate Partner Violence Among Females Aged 12 and Older, by Race/Ethnicity, 2001–2005 13

Table 3. Challenges, Barriers and Solutions to Addressing Intimate Partner Violence and Perinatal Depression. . . 18

Table 4. Summary of Intimate Partner Violence and Perinatal Depression Continuum of Care 23

Section 2: Assessing Readiness 26

Tool 1. Pre-Program Assessment 27

Section 3: Strategies for Building and Sustaining Partnerships 39

Tool 1. Establishing an Intimate Partner Violence/Perinatal Depression Work Group 53

Tool 2. Community Resource Inventory for Recognizing Potential Partners. 55

Tool 3. Sample Memorandum of Understanding 57

Section 4: Raising Awareness. 61

Tool 1. Plan of Action for Raising Awareness 77

Section 5: Cultural and Linguistic Competency 81

Tool 1. Cultural Considerations in Your Community 87

Section 6: Policy 96

Tool 1. Policy Brainstorming 101

Section 7: Standards of Care Guidelines and Recommendations for Intimate Partner Violence and Perinatal Depression 105

Table 1. Screening Tools for IPV and PD 118

Tool 1. Example of a Referral Care Pathway Model 119

Section 8: Evaluation of Your Efforts. 123

Tool 1. Post-Program Assessment 126

Tool 2. Recommendations for Improvement 134

INTRODUCTION

A feeling of optimal mental and emotional health is critical to a mother's well-being, parenting abilities, and interpersonal relationships. A life free of violence, including intimate partner violence (IPV), is also directly related to the mental health of each mother and child. When experienced in tandem, IPV and perinatal depression (PD) severely affect pregnant and parenting women and their families, sometimes with serious consequences.

Although public awareness regarding the adverse maternal and child health outcomes associated with the intersection of maternal depression and intimate partner violence has increased, many pregnant and postpartum women experiencing both IPV and PD remain unidentified by health care providers (and others within the health and social support system) and consequently fail to receive timely and necessary interventions.

Goal of this toolkit: To highlight innovative state and community-based strategies and provide a resource that assists community-based organizations with addressing the intersection of intimate partner violence and perinatal depression.

Audience: Community-based organizations working with women, children and families.

This toolkit was developed with the understanding of the multifactorial aspects that increase the risk of perinatal depression and intimate partner violence such as behavioral, social, cultural, and environmental factors and the complexity of the interaction of these factors. The goal of this toolkit is to serve as a resource that assists organizations with addressing IPV/PD simultaneously by providing assessment tools, links to national resources, and highlighting promising practices and evaluation tools to assess your efforts. This toolkit focuses on providing community-based organizations with an introduction to these issues and the many ways they can be addressed. Most importantly, this toolkit serves as a roadmap, providing resources and directing organizations to address IPV/PD from their unique standpoint. There are many resources that provide specific information concerning IPV or PD, as well as state and local policy efforts and coalitions already working in the community. These resources are included. However, the goal is not to specifically determine how organizations should address the intricacies and complexities of IPV/PD, but to provide tools that guide organizations through the process of dealing with these issues within their own diverse communities.

HOW TO USE THIS TOOLKIT

When intimate partner violence and perinatal depression are experienced by a woman and within a family and community, the negative consequences are far reaching. By taking action through raising awareness, forming partnerships, developing cultural competency, addressing policy, and implementing standards of care guidelines into the organization, the organization can more effectively address and support families experiencing IPV/PD.

This toolkit was created in a modular fashion. Depending on the organization, this toolkit can be used in various ways by incorporating appropriate elements into the organization or work environment as required. Some organizations may simply adapt existing policies or practices to include IPV/PD. Some may wish to focus on raising awareness and staff training. Still others may choose to use all of the materials.

This toolkit contains 8 sections (as shown in the Table of Contents). Section 1 highlights relevant research and statistics on IPV/PD and explains the issues in detail. This section may help your organization understand why IPV/PD should be addressed. Section 2 contains tools to assess readiness for organizational change, current assets, and potential challenges. It may be helpful to begin with this section before beginning another section. Sections 3-7 address the core strategies and tools that will be helpful in addressing IPV/PD in your community and can be used in any order, depending on the needs of the organization. Section 8 contains the post-assessment and should be used after the organization has used the toolkit and implemented efforts around IPV/PD. The post-assessment is meant to reflect on the efforts made, the challenges that are still apparent, and to consider what else could be done to successfully address IPV/PD.

No matter how this toolkit is used, we hope that it will contribute to a healthier and safer community.

Section 1

MAKING THE CASE TO ADDRESS INTIMATE PARTNER VIOLENCE AND PERINATAL DEPRESSION

STRATEGIC OVERVIEW

Although public awareness has increased regarding the adverse maternal and child health outcomes associated with the intersection of perinatal depression (PD) and intimate partner violence (IPV), many pregnant and postpartum women experiencing both IPV and PD remain unidentified by health care providers and consequently fail to receive necessary interventions.

Understanding IPV and PD, who is affected, and how the two are connected is an important first step to being able to address IPV/PD in your community. This section will provide statistics and background information about IPV and PD.

Goals of this Section:

1. Provide information on intimate partner violence (IPV) and perinatal depression (PD)
2. Describe the relationship between IPV and PD
3. Highlight potential challenges and barriers in addressing IPV/PD
4. Identify best practices for identifying and treating IPV/PD

DEFINITIONS OF INTIMATE PARTNER VIOLENCE AND PERINATAL DEPRESSION

Intimate Partner Violence

The World Health Organization (WHO) defines IPV as, "....any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in that relationship. It includes acts of physical aggression (slapping, hitting, kicking or beating), psychological abuse (intimidation, constant belittling or humiliation), forced sexual intercourse or any other controlling behavior (isolating a person from family and friends, monitoring their movements and restricting access to information or assistance)" (WHO n.d.). Intimate partner violence, as defined by the Centers for Disease Control and Prevention (CDC), describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (CDC, 2010, a) [1]. Often the term domestic violence is used interchangeably with intimate partner violence. For the purposes of this toolkit, IPV describes the violence taking place between partners. Issues of coercion and deprivation of liberty are also important in identifying IPV.

1 Intimate partner violence (IPV) is the terminology we will use for the purposes of this project. Please note that there will be references to other types of violence and alternate terminology as cited in the literature.

There are five types of intimate partner violence as defined by the CDC (CDC, 2010, a; Saltzman, Fanslow, McMahon & Shelley, 2002):

Physical violence is "the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to: scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person (CDC, 2010, a; Saltzman et al., 2002)."

Sexual violence encompasses three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact (CDC, 2010, a; Saltzman et al., 2002).

Threats of physical or sexual violence include the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm (CDC, 2010, a; Saltzman et al., 2002).

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources [2]. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence (CDC, 2010, a; Saltzman et al., 2002).

Stalking is often included among the types of IPV (CDC, 2012). Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property (Tjaden & Thoennes, 1998)."

The following figure depicts multiple forms of abuse and violence that allow a perpetrator to establish and maintain power and control by creating an intimidating, threatening environment. The Power and Control Wheel in Dating Relationships, developed by the Kansas Coalition Against Sexual and Domestic Violence and adapted from the Power and Control Wheel developed by the Domestic Abuse Intervention Programs, Duluth, MN, illustrates how many different actions fit into a larger system of abuse and violence.

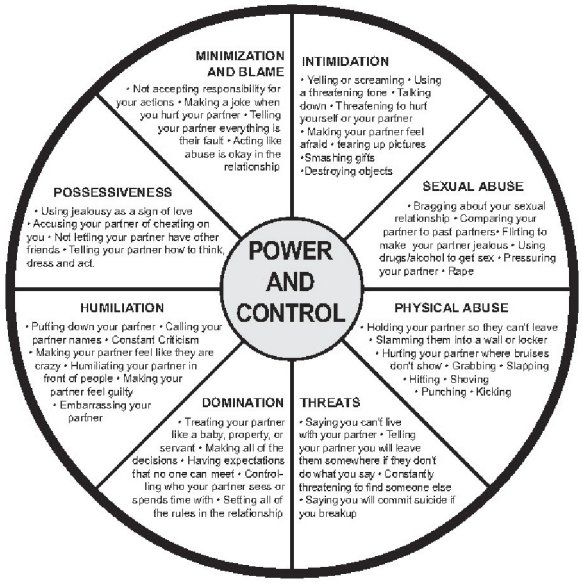


Figure 1. Power and Control Wheel Demonstrating Common Intimate Partner Violence Experiences.

2 Survivor is the terminology we will use for the purposes of this project. Please note that there will be references to alternate terminology (victim) as cited in the literature.

Perinatal Depression

Perinatal depression (PD) is a multifaceted condition which includes both physical and emotional effects that can occur before, during, and after birth (National Institute for Health Care Management [NIHCM], 2010). The term PD is used here to describe a spectrum of conditions: prenatal depression, postpartum blues, postpartum depression, and postpartum psychosis (CDC, 2010, b).

Prenatal depression affects approximately 14 to 25 percent of pregnant women (Stroud, Niaura, Lagasse & Lester, 2004). Fifty percent of these women will then develop postpartum depression following the birth of the child, so early identification and treatment is essential. Symptoms of the mother include irritability, tearfulness, anxiety, and insomnia.

Postpartum blues is considered normal and generally occurs within the first 10 days after childbirth, affecting up to 80 percent of new mothers (American Congress of Obstetricians and Gynecologists [ACOG], 2009). Symptoms of the mother include tearfulness, fatigue, insomnia, anxiety, and feelings of loss or being overwhelmed. However, these symptoms are generally mild, do not affect infant care, and generally resolve in the first 10 days after childbirth.

Postpartum depression is clinically significant and requires medical attention. Symptoms of the mother include prolonged sadness, irritability, sleep and appetite disturbance, guilt, decreased concentration, and thoughts of harming herself or the child. These symptoms can last weeks or up to one year after childbirth and affects an estimated 6.5-12.9 percent (Gaynes, Gavin, Melzer-Brody, Lohr, Swinson, Gartlehner, Brody & Miller, 2005). Additionally, 8.5-11 percent of women will experience this depression during the pregnancy (Gaynes et al., 2005). The American Academy of Pediatrics (AAP) estimates that during the postpartum period, up to 85 percent of women experience some type of mood disturbance; AAP estimates that more than 400,000 infants are born each year to mothers who are depressed (Horowitz, Murphy, Gregory & Wojcik, 2009).

Postpartum psychosis is a less common, but more severe form of postpartum depression which can include hallucinations, paranoia, suicide, or infanticide, requiring emergency attention. This condition is rare affecting 0.1-0.2 percent of women each year (US Preventive Services Task Force, 2009; Scottish Intercollegiate Guidelines Network, 2002; Kendall, Chalmers & Platz, 1987; O'Hara, Neunaber & Zekoski, 1984). Women have a higher risk of postpartum psychosis if they have experienced bipolar disorder or schizophrenia, and if they have a family history of these diseases (ACOG, 2011).

Several factors are thought to predispose women to perinatal depression such as biological factors, including hormonal and chemical changes experienced during pregnancy; genetic factors; family history of depression; and previous history of maternal depression (Rojas, Fritsch, Guajardo, Rojas, Barroilhet & Jadresic, 2010; Marcus, 2009; Burt & Quezada, 2009; Epperson, 2002; Leckman & Herman, 2002). Furthermore, perinatal depression may result from environmental factors including poor housing and lack of financial support, food, or family/partner support (Casey, Goolsby, Berkowitz, Frank, Cook, Cutts, Black, Zaldivar, Levenson, Hereen & Meyers, 2004). Lastly, stresses including intimate partner violence, traumatic experiences and substance abuse are highly associated with perinatal depression.

SIGNIFICANCE OF THE PROBLEM

Intimate partner violence (IPV) and perinatal depression (PD) are both extremely important public health concerns. Women from all sexual orientations, racial, ethnic, cultural and socioeconomic backgrounds and of all ages are at risk for experiencing both PD and IPV. It is important to note that a majority of data specific to prevalence and trends relies mostly on self-reporting. The shame and stigma associated with both violence and depression often prevent women from reporting. As a result, prevalence data regarding rates of IPV and PD are often severely underestimated.

Intimate Partner Violence

The sensitive nature of violence against women and the lack of screening and diagnosis lead to severe underreporting and difficulty collecting an accurate picture of the prevalence of IPV. In spite of these barriers, in their review of 9 population-based, random surveys of couples and individuals Field and Caetano (2005) concluded that intimate partner violence is reported by approximately 20 percent of US couples. The CDC's report on the National Intimate Partner and Sexual Violence Survey (NISVS) of 2010 estimates that more than 1 in 3 women (35.6 percent) have experienced intimate partner violence in their lifetime (CDC, 2011). Almost 1 in 4 women (24.3 percent) have experienced severe physical violence by an intimate partner (CDC, 2011). Almost half (48.4 percent) have experienced psychological aggression by an intimate partner throughout their lifetime (CDC, 2011). Furthermore, women experiencing intimate partner violence are more likely to experience multiple forms of violence which includes physical violence, rape, and stalking (CDC, 2011).

Perinatal Depression

The American Academy of Pediatrics (AAP) states that perinatal depression is the most under-diagnosed obstetric complication in the United States (Earls & The Committee on Psychosocial Aspects of Child and Family Health, 2010). In fact, women during their childbearing years account for the largest group of Americans with depression (ACOG, 2007 May 7). Although a national estimate of PD vary, recent research places rates of depression during pregnancy or postpartum between 10-20 percent (NIHCM, 2010). The CDC's analysis of population-based Pregnancy Risk Assessment Monitoring System (PRAMS) data from 17 states in 2004-2005 confirms this range of prevalence rates, with self-reported rates of postpartum depression falling between 11.7 percent and 20.4 percent (CDC, 2008). ACOG estimates a slightly higher rate, with 23 percent of women exhibiting more serious and persistent depressive symptoms following childbirth, and as high as 80 percent of women experiencing a more normal, low form of depression called "baby blues" (ACOG, 2009).

WHO IS AFFECTED

Women of all groups experience IPV and PD regardless of age, race, ethnicity, orientation, marital status and socioeconomic status. However, research indicates that certain groups are at a higher risk of experiencing both IPV and PD. Understanding IPV/PD risk factors is important in successfully addressing IPV/PD in your community.

Intimate Partner Violence

The Bureau of Justice Statistics' data from the National Crime Victimization Survey (NCVS) and Uniform Crime Reporting (UCR) between 2001-2005 indicate that women in their reproductive years experience higher rates of IPV (Catalano, 2007). In this study, non-pregnant women ages 20-24 were the most likely to experience IPV (11.3 per 1,000), followed by women ages 25-34 (8.1 per 1, 000) (Catalano, 2007). Please refer to Table 1. U.S. Rates of Intimate Partner Violence Among Females Aged 12-64, by Age, 2001–2005 (pg 13). Rates of IPV for pregnant women vary, as detailed in the section below describing connections between IPV and PD.

Catalano (2007) found that women in households with annual incomes below $7,500 had the highest

rate of intimate partner victimization (12.7 per 1,000 women) compared to all other income levels. Those in households with annual incomes of $50,000 or more were least likely (2 per 1,000 women) to experience intimate partner violence (Catalano, 2007). In terms of race/ethnicity, American Indian/ Alaska Native women experienced the highest rate of IPV (11.1) followed by Black women (5), with Asian women least likely to be victims of IPV (1.4). (All per 1,000 women ages 12 and older) (Catalano, 2007). Please refer to Table 2. U.S. Rates of Intimate Partner Violence Among Females Aged 12 and Older, by Race/Ethnicity, 2001–2005 (pg 13).

Tjaden and Thoennes' (2000) analysis of the National Violence Against Women Survey (NVAWS) shows that ethnic minorities in general experience more IPV than whites. Specifically, American Indian/ Alaska Native, African American, and Hispanic women have been found to report significantly higher rates of IPV than women of other racial backgrounds, with American Indian/Alaska Native women again reporting a higher rate of victimization than all other groups (Tjaden & Thoennes, 2000). Rennison and Welchans' analysis of the National Crime Victimization Survey (NCVS) concluded that Black women's intimate partner victimization was 35 percent higher than Caucasian women and almost 2 times higher than the rate of victimization for women of other races (Rennison & Welchans, 2000). Varying rates of IPV by race/ethnicity may be accounted for by the differing methodologies and survey questions asked in the NVAWS and NCVS however, Field and Caetano's (2005) review suggests that even when controlling for socio-demographic factors, as well as a history of violence between parents, history of victimization by violence during childhood, drug and alcohol use, and the presence of alcohol problems, Black women still reported higher rates of IPV than other racial/ethnic minority groups.

Immigrant women in particular (both documented and undocumented) are more vulnerable to violence. A growing body of research indicates that immigrant women have fewer resources, stay longer in relationships, and sustain more severe physical and emotional consequences than other women in the United States (Shoultz, Magnussen, Manzano, Arias & Spencer, 2010; Raj & Silverman, 2002; Abraham, 2000; Dutton, Orloff & Hass, 2000; Anderson, 1993). For immigrant women the conditions that facilitate isolation and control by an abuser are even more prominent.

IPV is experienced by women in heterosexual and homosexual relationships. Tjaden, Thoennes, and Allison (1999) also found that 11.4 percent of women in intimate relationships with women experience IPV. Women reporting violence perpetrated by their female partners additionally reported experiencing IPV by previous male partners.

Perinatal Depression

The CDC's 2004-2005 PRAMS data revealed that among self-reported rates of postpartum depression, race/ethnicity, maternal age, marital status, maternal education, and Medicaid delivery coverage were all significantly associated with postpartum depression (CDC, 2008). Goyal, Gay & Lee's (2010) review reveals that there are other similar or associated risk factors for postpartum depression, such as adolescent pregnancy, which might explain why age is a common risk factor, and poor relationship satisfaction, which could partially explain why marital status or cohabitating status is sometimes listed as a risk factor as well as a lack of social support. Additionally, a family history of depression and a personal history of depression (and specifically perinatal depression with a previous pregnancy) can affect the prevalence of perinatal depression for all women (NIHCM, 2010).

Although CDC data show that non-Hispanic white women reported the lowest rate of postpartum depression (CDC, 2008), several studies confirm that race/ethnicity has less of an impact than factors associated with low socioeconomic status (such as low income, low educational attainment, unemployment, younger age, lack of social support, lack of financial support, and lack of partner support). Specifically, studies show that younger women with lower educational attainment and lower income have the highest prevalence rates of postpartum depression (Goyal et al., 2010, Mayberry, Horowitz & Declercq, 2007; Segre, O'Hara, Arndt & Stuart, 2007; Rich-Edwards, Kleinman, Abrams, Harlow, McLaughlin, Joffe & Gillman, 2006; Bohn, Tebben & Campbell,

Table 1. U.S. Rates of Intimate Partner Violence Among Females Aged 12-64, by Age, 2001–2005

Source: (Catalano, 2007). U.S. Department of Justice, Bureau of Justice Statistics.

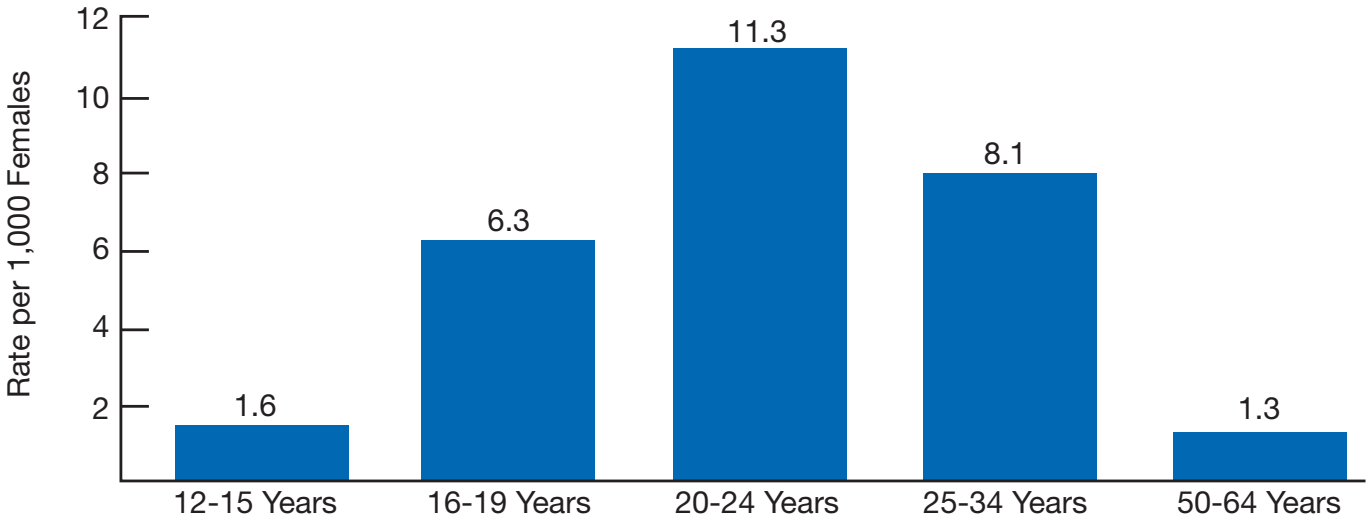
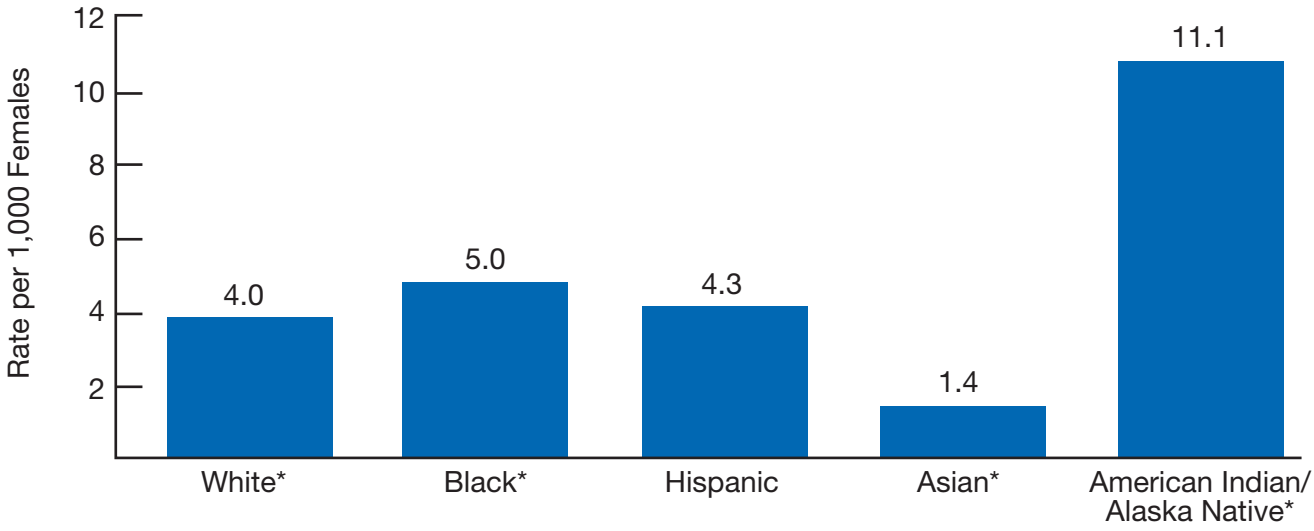


Table 2. U.S. Rates of Intimate Partner Violence Among Females Aged 12 and Older, by Race/Ethnicity, 2001–2005

Source: (Catalano, 2007). U.S. Department of Justice, Bureau of Justice Statistics.



* May Include Hispanics.

2004; Beeghly, Olson, Weinberg, Pierre, Downey & Tronick, 2003).

In their longitudinal, randomized study of 198 women recruited from childbirth education classes and prenatal clinics, Goyal et al. (2010) found that partnered women with risk factors associated with lower socioeconomic status (lower income, unemployment, lower education and unmarried status) were 11 times more likely to develop postpartum depression than women without the indicated lower socioeconomic risk factors. In their sample of 1278 women completing a questionnaire mid-pregnancy and 6 months postpartum, Rich-Edwards et al. (2006) found that risk factors for depressive symptoms included being younger, less educated, having fewer financial resources, and without a spouse or cohabitating partner. Even as Black and Hispanic women had higher prevalence of depression, when controlling for age and lack of financial resources, race/ethnicity was not a statistically significant risk factor (Rich-Edwards et al., 2006). Indeed, multiple studies place perinatal depression rates for younger, low-income women between 40-60 percent (Earls & The Committee on Psychosocial Aspects of Child and Family Health, 2010). Furthermore, due to the impact of social stressors and lack of social support on perinatal depression, lesbian and bisexual women may be at a greater risk for perinatal depression than heterosexual women (Ross, Steele, Goldfinger, & Strike, 2007; Trettin, Moses-Kolko & Wisner, 2006).

It is important to keep in mind that low-income status disproportionately affects African-American and Hispanic women in the US (Meltzer-Brody, 2011). Therefore, although recent research concludes that race/ethnicity is not always a statistically significant risk factor for perinatal depression, socioeconomic risk factors are more likely to impact racial/ethnic minority women.

THE CONNECTION BETWEEN IPV AND PD

Although there are no national prevalence estimates of IPV against pregnant women (GAO, 2002), most research indicates that the rates of physical abuse for pregnant women fall between 2.1 and 6.3 percent (Charles & Perreira, 2007; Silverman, Decker, Reed & Raj, 2006; Yost, Bloom, McIntire & Leveno, 2005, Gazmararian, Lazorick, Spitz, Ballard, Saltzman & Marks, 1996). Yet in their comprehensive review, Gazmararian, Petersen, Spitz, Goodwin, Saltzman & Marks (2000) found rates of IPV during pregnancy ranging from 1 to 20 percent. Indeed, some research has shown that pregnant women are at an increased risk of violence (Jasinski, 2004). Differences in rates of IPV during pregnancy can be attributed to the variety of differences in sample sizes, timing of studies conducted, methodology, definition and measures of violence (Talbot, Tang & Chaudron, 2011; Taillieu & Brownridge, 2010). Regardless of specific rates of IPV during pregnancy, pregnancy can represent a time of increased vulnerability for IPV due to increased physical, emotional, and financial needs (Taillieu & Brownridge, 2010). Multiple biological, social, and economic factors can increase one's risk of experiencing IPV (National Center on Domestic Violence, Trauma, and Mental Health [NCDVTMH], 2011). It follows that the unique biological, social, and economic stressors associated with pregnancy have the potential to affect pregnant women's experience of IPV.

Research shows that IPV can strongly increase one's risk of experiencing depression. IPV survivors report greater medical service use and an increased mental health burden that includes depression, posttraumatic stress disorder (PTSD), suicidal thinking, and suicide attempts (Cerulli et al., 2011). Cerulli, et al. (2011) found that in their study, "… IPV was one of the most important independent risk factors for antenatal depression, increasing a woman's odds for antenatal depression by more than three times." As Stampfel, Champman & Alvarez (2004) aptly conclude, IPV has been connected to mental health issues in non-pregnant women, and as, "Pregnant women represent

a population susceptible to mental health disturbance postpartum, so it would seem logical to examine the effect of pregnancy in victims of IPV." Dunn and Oths' (2004) study found that women experiencing IPV during pregnancy were 2.5 times more likely to report being depressed than those not experiencing IPV. Still other research finds that IPV is strongly associated with perinatal depression in particular, along with other social stresses such as marital relations, work, finances, and housing (Husain, Chaudhry, Saeed, Khan, Hassan & Husain, 2009).

In addition, depression and mental health illness have been associated with an increased risk of experiencing IPV (NCDVTMH, 2011; McDonnell, Burke, Gielen & O'Campo, 2006). Warshaw and Barnes (2003) find that women experiencing depression or other mental illness have a higher risk of violent victimization and trauma than women without mental illness. The exact mechanism or causal relationship between co-occurring IPV/PD are not explicit, but the research clearly demonstrates a strong connection between risk factors for IPV/PD and experiences of IPV/PD. The distinctive stressors of pregnancy can exacerbate the physical, emotional, and social risk factors for experiencing both IPV and PD.

CONSEQUENCES OF IPV AND PD

Regardless of varying rates of IPV/PD prevalence, the negative effects of IPV are well documented and include preterm labor, low birth weight, future child abuse, and femicide (Cerulli et al., 2011). Survivors of intimate partner violence are more likely to experience complications during pregnancy (e.g. low maternal weight gain, infections, high blood pressure, vaginal bleeding) (Silverman et al.,

2006). IPV survivors are also less likely to have (or take advantage of) access to prenatal care and general health care (AAP & ACOG, 2007). They are at higher risk for substance abuse (Futures without Violence, 2012). Substance abuse and mental health disorders can intersect and in some cases exacerbate outcomes. Depression alone can also lead to adverse maternal and infant health outcomes. Specifically, maternal depression is associated with increased negative health behaviors such as substance abuse, noncompliance with a prenatal care regimen, and decreased ability to care for a newborn (NIHCM, 2010). Depression is also associated with preterm delivery and low birth rate (ACOG, 2007).

Children of women suffering from violence or mental illness (including depression) are: At risk for fetal and early childhood growth impairment if their impairment if their mother is exposed to any level of violence (Asling-Momemi, Naved & Persson, 2009). They are also at a significantly greater risk for a variety of psychosocial or physical problems (United Nations Children's Fund, 2005; Foa, Cascardi, Zoeliner & Feeny, 2000). Poor social, emotion, cognitive and physical child development can be related to the effect of PPD on mother-infant bonding and parenting and safety practices (Field, 2010).

Aside from negative maternal and infant outcomes, Taillieu and Brownridge's (2010) review finds that pregnant victims of IPV are at an increased risk for severe IPV, including femicide (Taillieu & Brownridge, 2010). Homicide (by a partner) accounts for 31 percent of all maternal injury deaths, and is the second leading cause of traumatic death for pregnant and postpartum women in the U.S. (Chang, Berg, Saltzman & Herndon, 2005). Unaddressed by tools for screening, treatment, and referral, the connection between IPV and PD can have dangerous consequences. Taillieu and Brownridge (2010) also find that, "Between 60% and 96% of women who are abused during pregnancy also report being abused in the past, suggesting that pregnancy violence represents a continuation of preexisting violence for most pregnant victims." If IPV/PD is only seen in the context of physical and/or mental health outcomes, there may be a missed opportunity to intervene and positively impact women's long-term experiences of violence (Stampfel, et al., 2004).

Long-term experiences of violence are extremely important to recorgnize, as having a history of trauma, violence, and abuse (including dating violence) are risk factors for future serious physical and mental health issues for women (Hahm, Lee, Ozonoff & Van Wert, 2010; Dube, Anda, Whitfield, Brown Felitti, Dong & Giles, 2005; Arnow, 2004; Mathews, Menacker & MacDorman, 2002; Silverman, Raj, Mucci & Hathaway, 2001). In cases where women, "have experienced multiple forms of victimization (e.g. childhood abuse; sexual assault; historical, cultural or refugee trauma), adult partner abuse puts them at even greater risk for developing posttraumatic mental health conditions, including substance abuse (a common method of relieving pain and coping with anxiety, depression and sleep disruption associated with current and/or past abuse). These conditions and coping strategies may, in turn, place them at risk for further abuse" (NCDVTMH, 2011). The individual experiences of IPV and PD as traumatic experiences are not only exacerbated by previous histories of trauma, abuse and depression, but can further contribute to a women's lifetime experience of trauma and mental health, placing her at greater risk throughout her lifetime. In addition, subtle forms of social and cultural victimization can be retraumatizing (NCDVTMH, 2011). Hence, even as IPV is associated with many negative mental health consequences for the general population, socially, economically, and culturally disenfranchised IPV survivors may experience other forms of trauma that impact their responses to IPV and PD (NCDVTMH, 2011).

It has been suggested that IPV during pregnancy may be more common than conditions such as preeclampsia, placenta previa, and gestational diabetes, all of which are routinely screened for during pregnancy (McFarlane, Parker & Soeken, 1996). Screening for IPV and PD is therefore incredibly important. Pregnancy may be the one of the only times women, especially of lower socioeconomic status, are connected with health care. Screening for IPV and PD gives health care providers

a unique opportunity to intervene and improve physical and mental health outcomes for mothers and infants, as well as contributing to larger efforts to end violence.

CHALLENGES AND BARRIERS TO ADDRESSING IPV AND PD

IPV and PD are not always co-occurring issues. There are many factors that affect and are affected by experiences of IPV and PD. Yet evidence suggests the importance of treating IPV and PD as potentially co-occurring issues, to ensure optimal health outcomes and overall wellbeing for pregnant and postpartum women. Addressing the co-occurrence of depression and IPV among pregnant and postpartum women is complex with barriers at the individual, provider, program and policy levels. One of these challenges is related to understanding IPV/PD as separate as well as potentially simultaneous issues. Additional structural challenges include provider training, ensuring privacy and protection for clients, and successful screening, referral and treatment mechanisms.

Although effective treatments for depression and other mental disorders exist, many individuals do not pursue treatment options because of challenges at the individual level such stigma, which often inhibits women from seeking care and support to address these issues. There are also barriers impacting access to care including financial barriers, and/or a general lack of awareness concerning the benefits of treatment. Furthermore, cultural and linguistic barriers, especially for many immigrant women, may prevent women from seeking help. Cultural barriers impact patient's conceptualization of health issues, their health literacy, patient's trust of the health care system, as well as perceptions of discrimination and provider attitude and sensitivity (Rodriguez, Valentine, Son & Muhammad, 2009). Table 3. Challenges, Barriers and Solutions to Addressing Intimate Partner Violence and Perinatal Depression (pg 18) offers suggestions for overcoming some of the major barriers or challenges in care and treatment for these co-morbidities. Please refer to Section 5: Cultural Competency (pg 82) and Section 7: Standards of Care (pg 106) for more information on addressing stigma, promising practices and recommended training curriculums.

Table 3. Challenges, Barriers and Solutions to Addressing Intimate Partner Violence and Perinatal Depression

Challenges and Barriers	Potential Solutions
Stigma associated with intimate partner violence and perinatal depression	Integrate IPV and PD services into other health care services that are less stigmatized, including primary and maternal care. Make it part of a more comprehensive service plan vs. a separate stand-alone issue. Increase awareness of IPV and PD in general public, specifically targeting at-risk or immigrant populations. Increase provider awareness and knowledge of IPV/PD, including training on comfortability in approaching IPV/PD issues with clients, appropriate trauma-informed responses to IPV and PD, awareness of creating safety plans, maintaining confidentiality, and empowering clients about their health. Create an empowering and safe environment for clients to discuss experiences of IPV and PD. Display empowering IPV resources in public settings, including fact sheets and posters. Develop culturally and linguistically competent IPV and PD screenings. Develop IPV/PD awareness materials that are culturally and linguistically competent.
Lack of provider knowledge and skills surrounding IPV and PD	Improve screening guidelines and protocols, offer physician trainings, and coordinate women's care across specialties. Increase provider awareness, knowledge of screening methods, and referral options/available interventions (e.g through trainings, continuing medical education courses, or working with national associations). Identify alternate health care providers to provide screenings (e.g. physician assistants, nurses, home visiting workers, social workers, WIC counselors). Increase IPV and PD as a health priority among the healthcare community (e.g. raise awareness). Integrate knowledge and skills-training surrounding IPV and PD into health education training. Collaborate with community organizations who already work with children, women and families. Address health insurance reimbursement policies to cover IPV and PD screening and counseling.

Challenges and Barriers	Potential Solutions
A focus on treatment rather than prevention	Collaborate with organizations who already serve children and families, particularly disadvantaged groups, to incorporate recognition and support services. These groups can be allies who help screen and identify, refer to treatment, and support families through the process. Integrate regular and routine screening protocols into healthcare practice.
Lack of care coordination across medical specialties	Improve care coordination across medical specialties. Screening and support services for PD and IPV can occur in any and all health specialties (i.e. not just OB/GYN or mental health care providers). Improve care coordination through a medical home model. Combine medical services with family supports, including parenting skills trainings, home visiting programs or family planning programs.
Limited best practice interventions and research	Invest in rigorous evaluations of current programs and in the development of new, innovative models. Improve the tracking/collecting of prevalence and incidence rates of IPV and PD.
Create a safe, empowering environment for clients	Include displaying IPV empowering resources in public settings. Share myths/facts sheets about IPV with staff and patients.

WHAT WORKS IN IDENTIFYING AND TREATING IPV AND PD

This section highlights potential screening and intervention strategies for perinatal depression.

Below is an overview of some of the promising practices and recommendations related to identifying and treating IPV and PD. Please refer to Section 7: Standards of Care (pg 106) for a more in-depth look at Standards of Care, Promising Practices, and additional resources and recommended curriculums and materials.

In order to adequately address IPV and PD, a clear continuum of care is recommended. This includes screening, referral and treatment. Figure 2 illustrates this continuum.

Perinatal Depression

Screening practices may include:

- Screening during pregnancy and also routinely over the 12 months following childbirth (Horowitz et al., 2009).
- Increased physician support, through accurate information and training (NIHCM, 2010).
- Tailoring materials and outreach appropriately for cultural competency and languages that are appropriate for the population(s) being served (Halbreich & Karkun, 2006).

Intervention strategies may include:

- Integrating PD services with other risk interventions delivered during pregnancy (e.g. addressing smoking, tobacco exposure, alcohol use, drug use, depression, and intimate partner violence together) (El-Mohandes, Kiely, Joseph, Subramanian, Johnson, Blake, Gantz & El-Khorazaty, 2008).
- Education and PD risk consultation for women during the third trimester (CDC, 2010).

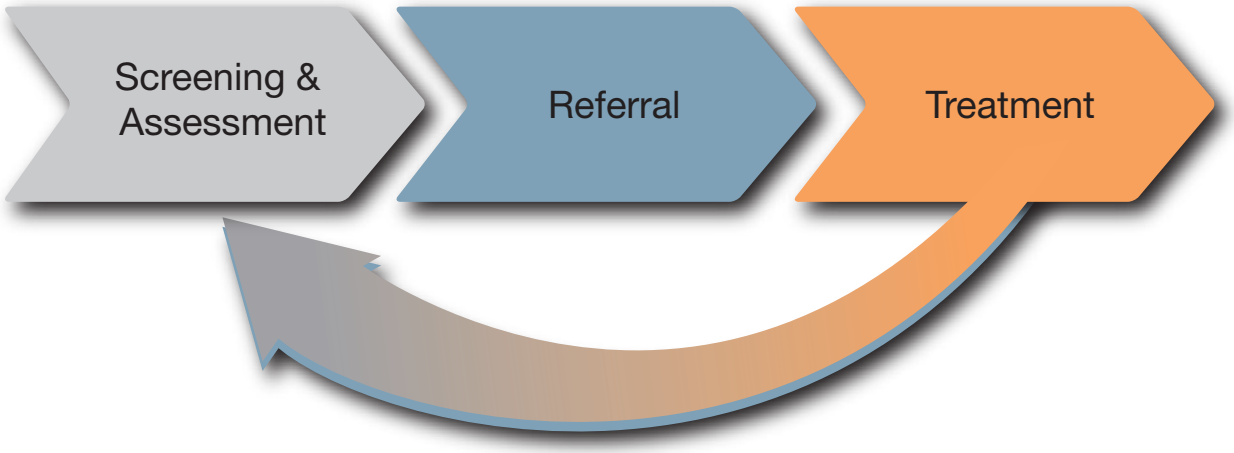


Figure 2. Screening & Assessment, Referral and Treatment Connections.

Once referral and treatments occur, it is important to rescreen and reassess throughout varying time points. Please refer to Section 3: Partnerships (pg 40) for more information on how to develop a Referral Care Pathway in your community. Please refer to Section 7: Standards of Care (pg 106) for more information on screening and assessment.

The section below highlights potential screening and intervention strategies for intimate partner violence. Screening practices involve creating a routine and specific screening protocol, ideally with one or multiple staff members dedicated to IPV screening.

Intimate Partner Violence

Screening practices may include (HHS, 2002):

- Provider/staff education and training, not simply on the issue of IPV, but how to relate this information to clients and discuss IPV in a safe, empowering way.
- Concrete tools and strategies, with clear procedures and policies in place for staff to follow, especially concerning mandated reporting, maintaining confidentiality, and establishing safety plans.
- Collaboration with IPV-focused organizations such as domestic violence shelters to coordinate training and resources.

Universal Assessment for Intimate Partner Violence and Perinatal Depression

- The majority of women do not mind being asked about PD or IPV.
  - 80 percent of women are comfortable with the depression screening process (Buist, Condon, Brooks, Speelman, Milgrom, Hayes, Ellwood, Barnett, Kowalenko, Matthey, Austin & Bilszta, 2006)
  - 90 percent of women are comfortable with the IPV screening process (Zeitler, Paine, Breitbart, Rickert, Olson, Stevens, Rottenberg & Davidson, 2005)
- Yet, the majority of women are not asked about PD or IPV.
  - Less than 50 percent of women are screened for PD (Seehusen, Baldwin, Runkle & Clarke, 2005)
  - Only 22 percent of providers use a validated screening tool for PD (Seehusen et al., 2005)
  - Only 10 percent of women report screening for IPV by their OB/GYNs (Rodriguez, Bauer, McLoughlin & Grumbach, 1999)

Intervention strategies may include:

- A strong focus on prevention through collaboration with organizations who already serve children and families, particularly disadvantaged groups, to incorporate recognition and support services.
- Integrated, holistic, and individualized care plans (HHS, 2009). Ensuring service provision as part of the continuum of care, and individualized care plans.
- Consider targeted interventions for perpetrators in addition to survivors.

INTIMATE PARTNER VIOLENCE AND PERINATAL DEPRESSION AS CO-MORBIDITIES

The previous section outlined specific evidence-based approaches to effectively address IPV and PD separately. This section will describe components of strategies that can be integrated with existing IPV/PD strategies to enhance/improve efforts. Table 4. Summary of Intimate Partner Violence and Perinatal Depression Continuum of Care (pg 23) provides a summary of IPV and PD continuum of care.

IPV and PD are under-recognized, under-diagnosed, and under-treated. IPV/PD affects all groups, regardless of race, ethnicity, socioeconomic status, sexual orientation, or age. Additionally, it is clear that there are negative impacts on children when mothers experience IPV/PD. Components of strategies that can enhance or improve efforts to combat IPV/PD include screening women for both IPV and PD, undertaking interventions with psychosocial and behavioral components, or those based on a theoretical framework emphasizing social support and the strengthening of social relationships, like Interpersonal Psychotherapy (El Mohandes et al., 2008; Zlotnick, Capezza & Parker, 2012). It is also important to design protocols focused on fostering women's empowerment and independence, as well as those that focus on empathy, and the need to listen and accept a women's perceptions and feelings (Tiwari, Leung, Leung, Humphreys, Parker & Ho, 2005). Finally, partnering with uncommon providers such as tobacco cessation programs, basic health education services, transitional housing, substance abuse, mental health, WIC, and other social services may be a powerful resource for creating IPV/PD intervention strategies (National Association of County and City Health Officials [NACCHO], 2008).

Table 4. Summary of Intimate Partner Violence and Perinatal Depression Continuum of Care

Issue	Who	Intersection	Effects	Screening	Intervention
IPV	Women of all racial and economic backgrounds (more prevalent among minority women, those with less than a high school education, receiving government assistance or women in their reproductive years). Pregnant women experience physical abuse at estimated rates of 2.1 to 3.3 percent. Vast underreporting likely for estimated rates.	May be exacerbated during pregnancy.	Complications during pregnancy, risk for low weight/preterm delivery, increased substance abuse, and less likely to utilize prenatal or general health care.	Integrate screening through social service providers (e.g. WIC, transitional housing, substance abuse).	Focus on prevention, and provide interventions that target perpetrators.
PD	Prenatal depression affects 14-25 percent of pregnant women, 80 percent of new mothers experience postpartum blues, and postpartum depression can affect up to 20 percent of women. Women of all racial and economic backgrounds are affected and in varying degrees of severity. Vast underreporting likely for estimated rates.	Affects women suffering from IPV at a higher rate.	Compromised mother-infant bonding and safety practices; poor child development indicators; psychosocial and physical problems.	Emphasize cultural and linguistic appropriateness.	Provide integrated risk interventions before, during, and after pregnancy (e.g. address smoking, tobacco exposure, depression, and intimate partner violence together).
IPV and PD	There is no difference between populations that experience IPV/PD in tandem and those that experience IPV or PD individually.	Clear, though undefined interaction between PD and IPV. Appears to be a cycle of IPV contributing to PD, and PD contributing to IPV.	Fetal and early childhood growth impairment; see above.	Integrate screening into primary, gynecologic and pediatric care.	Focus on empowerment and acknowledgement of women's thoughts and feelings as valid.

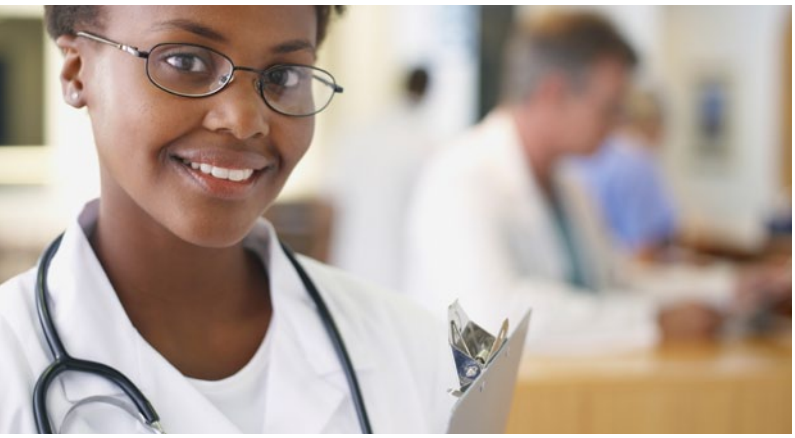
NOTES PAGE

Section 2



ASSESSING READINESS

STRATEGIC OVERVIEW



Goals of this Section:

1. Determine the organization's level of readiness for change
2. Determine the level of support from staff and leadership to implement IPV/PD initiatives
3. Determine staff training needs as related to IPV/PD and cultural competency
4. Determine environmental and procedural changes that might be necessary to implement IPV/PD initiatives within the organization
5. Identify current assets and potential challenges to implementing IPV/PD initiatives within the organization

An organization is composed of an intricate group of systems working together to meet its goals. In order to undertake a new initiative, it is important to determine if the organization is ready to make a change. An assessment of the organization leadership, resources, and support to effectively take on the new initiative, especially given the complexities of intimate partner violence (IPV) and perinatal depression (PD) is warranted. This section of the toolkit provides an assessment tool that will help assess the organization's readiness for change and ability to successfully address IPV and PD. Additionally, refer to Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression (pg 8) before facilitating this activity to ensure a shared understanding of the issues.

The assessment tool offers a series of questions designed to prompt organizations to think about the four key factors: 1) level of leadership and staff support support, knowledge, and comfort in addressing IPV/PD; 2) staff training needs; 3) existing protocols and guidelines related to IPV/PD; and 4) challenges concerning resources, partnerships, and community awareness that will impact an organization's readiness for change. The assessment tool allows organizations to think about their unique situation, and create a plan of action to move forward in addressing IPV/PD. The modular sections following the assessment provide information designed to guide organizations through the process of transitioning to address IPV/PD as co-occurring issues by providing resources and strategies based on each organization's needs, readiness for change, and goals for addressing IPV/PD in their community.

Tool 1. Pre-Program Assessment

This tool will assist you in assessing organizational readiness for change, current assets and resources, and potential challenges to addressing IPV/PD. Remember, there is no right or wrong answer. The tool simply guides you and your organization in thinking about how ready you are to implement IPV/PD in several different areas. The modules throughout this toolkit are designed to provide resources for addressing IPV/PD at any stage.

Each organization is unique and must assess their unique situation when considering addressing IPV/PD. The tool should be completed by staff as a group, and not by one individual. Meet with the staff to review the results of the assessment. The discussion of this tool could be the topic of a staff meeting where all can provide input and strategies for improvement. The meeting facilitator could ask staff members which of the items highlighted by the observation tool could be changed easily, which they would like to change, and which the team should prioritize.

An action plan could be developed based on the items that staff members identify as feasible, realistic, and most important to providing IPV/PD services.

I. Readiness for Change

1. Implementing programming related to intimate partner violence (IPV) and perinatal depression (PD) is in line with our organization's mission.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

2. Addressing IPV/PD is a priority for our leadership.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. We have support and commitment from leadership to make changes necessary to address IPV/PD.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

4. Addressing IPV/PD is a priority for our staff.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

5. Our staff is supportive and committed to making change to better address IPV/PD.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

6. Our organization is ready to implement changes related to IPV/PD.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

7. We are ready to carry out changes that will be necessary to address IPV/PD as it relates to:

   a) Adopting evidence-based and best practices related to IPV/PD

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   b) Applying new approaches and strategies related to IPV/PD

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   c) Applying new screening tools and Standards of Care guidelines for IPV/PD

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   d) Developing new leadership styles

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   e) Increasing staff capacity to adopt and implement strategies for addressing IPV/PD

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

II. Staff and Training

Active Caseload _____ Total Staff _____

Describe breakdown of staff (e.g. number of administrative, front line, supervisors, etc.)

Type of Staff	Number Currently on Staff
Administrative	
Nurses, Physician Assistants, Medical Assistants	
Supervisors	
Providers/Physicians	
Social Worker or Case Workers	
Patient Advocates	
Health Educators	
Language Interpreters	
Marketing, Communications, Public Relations	
Other (specify and identify number for each)	

1. How has our organization worked with/addressed intimate partner violence (IPV) and perinatal depression (PD) in the past?

_____

_____

_____

2. How are new staff trained on their job duties overall?

_____

_____

_____

3. Is IPV/PD part of the new staff training?

☐ Yes ☐ No

If yes, please explain.
If no, how could IPV/PD information be incorporated into existing trainings?

_____

_____

_____

4. In the past three years, what types of training has all staff been provided through local or statewide training events regarding IPV/PD?

Training Topics	How Provided (face-to-face, on-line, train-the-trainer)

5. If there have been trainings related to IPV/PD, how effective do you think the training was for your staff?

_____

_____

6. If there have been trainings, has there been a change in the way staff provide services because of the training?

☐ Yes ☐ No

If yes, please explain any changes.
If no, explain why there has been no change in the provision of services.

_____

_____

_____

7. How confident are you that staff can apply new skills learned in training?

Not confident	Somewhat Confident	Confident	Very Confident
☐	☐	☐	☐

8. Based on your understanding of IPV/PD, what current policies and procedures support staff in providing quality services to persons experiencing IPV/PD?

_____

_____

_____

III. Guidelines/procedures

1. Are there guidelines and procedures in place for assessing and screening clients who are experiencing IPV/PD?

   ☐ Yes ☐ No (If no, skip to question 4)

   If yes, what are they?

   _____

   _____

   _____

2. Are there guidelines and procedures in place for referring clients who are experiencing IPV/PD?

   ☐ Yes ☐ No

   If yes, what are they?
   If no, what has been the barrier to having referral procedures?

   _____

   _____

   _____

3. Are there guidelines and procedures in place for treating clients who are experiencing IPV/PD?

   ☐ Yes ☐ No

   If yes, what are they?
   If no, what has been the barrier to having treatment procedures?

   _____

   _____

   _____

4. Are there policies and procedures that (accidentally/indirectly/not on purpose) are barriers to staff providing quality services to persons experiencing IPV/PD?

   ☐ Yes ☐ No

   If yes, please describe any barriers

   _____

   _____

   _____

5. What, if any, guideline/policy changes has the staff made over the past year to make services more accessible to persons experiencing IPV/PD?

_____

_____

_____

6. What guideline/policy changes has you/your staff thought about making to improve services for persons experiencing IPV/PD? Why haven't they been implemented yet?

_____

_____

_____

IV. Referrals and Participant Feedback

1. Do staff routinely refer participants to other programs or organizations for IPV/PD services

   ☐ Yes ☐ No (If no, skip to question 3)

   If yes, to which programs/organizations do you routinely refer participants?

   a. _____

   b. _____

   c. _____

   d. _____

2. What processes do you have in place to ensure the referral is completed?

   _____

   _____

   _____

3. What processes do you have in place to collect feedback from participants and partners about your services?

   _____

   _____

   _____

V. Partnerships

1. What partnerships with community or public agencies exist to provide high quality services to your clients overall?

   a. _____

   b. _____

   c. _____

   d. _____

2. What partnerships exist specifically related to IPV or PD?

   a. _____

   b. _____

   c. _____

   d. _____

3. Are these partnerships beneficial?

   ☐ Yes ☐ No

   If yes, explain how they are beneficial.
   If no, explain why these partnerships are not beneficial.

   _____

   _____

   _____

VI. Raising Awareness

1. Do you feel that your staff is aware of the relationship between IPV and PD?

   ☐ Yes ☐ No

   a. What do they already know about IPV/PD?

   _____

   _____

   _____

   b. What could you improve?

   _____

   _____

   _____

2. Is your program participating in a public IPV/ PD awareness campaign within your community?

   ☐ Yes ☐ No

   If yes, what is the campaign?
   If no, why not participate?

   _____

   _____

   _____

3. Does your program have guidelines and clear processes for how to effectively work with local media?

   ☐ Yes ☐ No

   If yes, what are the guidelines/processes?
   If no, why are there not guidelines/processes in place?

   _____

   _____

   _____

4. Do you feel that members of your community are aware of IPV/PD and know where to seek help?

   ☐ Yes ☐ No

   a. What do members of your community already know about IPV/PD?

   _____

   _____

   _____

   b. What information are they lacking?

   _____

   _____

   _____

5. Does the physical environment of the organization's clinic/office have posters, brochures or awareness materials related to IPV/PD?

   ☐ Yes ☐ No

6. Does your organization's website have a section dedicated to information about IPV/PD?

   ☐ Yes ☐ No

VII. Cultural Competency

1. Do staff members represent the cultures and languages of your target population?

   ☐ Yes ☐ No

   a. What cultures and languages are represented among your staff?

   _____

   _____

   _____

2. Do staff receive training about the cultures, beliefs and stigmas that may be associated with families seeking services for IPV/PD?

   ☐ Yes ☐ No

   If yes, please describe the training.
   If no, how could this information be incorporated into existing trainings?

   _____

   _____

   _____

3. Does the physical environment of the organization's clinic/office have posters, brochures or awareness materials that are culturally and linguistically competent?

   ☐ Yes ☐ No

4. Does the organization provide bi-lingual services?

   ☐ Yes ☐ No

5. Does your organization have a language access plan that includes plans for access to a language line and/or interpreters?

   ☐ Yes ☐ No

6. Is the organization currently conducting bi-lingual outreach within the community?

   ☐ Yes ☐ No

7. Does the organization have a relationship with culturally specific community-based service providers in the area?

   a. If so, do you have a Memorandum of Understanding (MOU) signed?

      ☐ Yes ☐ No

   b. If yes, do you refer clients to these organizations?

      ☐ Yes ☐ No

VIII. Standards of Care

1. Does the organization utilize Standards of Care Guidelines for IPV and PD?

☐ Yes ☐ No

If yes, what guidelines are you currently using?
If no, what has prevented the organization from adopting these guidelines?

_____

_____

_____

2. Does the organization have a standard screening tool to use in practice for IPV or PD?

☐ Yes ☐ No

a. If yes, which screening tools are you currently using?
If no, what are the barriers to identifying and using Standards of Care guidelines?

_____

_____

_____

b. If yes, does the tool address both IPV and PD or do you need to use two separate screening tools?

☐ Addresses Both ☐ Need Two Separate Tools

3. Have staff been trained in how to screen women for IPV/PD using the Standards of Care guidelines and recommended techniques?

☐ Yes ☐ No ☐ Not Applicable

If yes, please describe the training.
If no, how could this information be incorporated into existing trainings?

_____

_____

_____

4. Do you feel your staff could use additional training on Standards of Care?

☐ Yes ☐ No ☐ Not Applicable

If yes, specifically what could be added? (For example, how to discuss IPV/PD with women and how to utilize recommended screening tools)

_____

_____

_____

NOTES PAGE

NOTES PAGE

Section 3

STRATEGIES FOR BUILDING AND SUSTAINING PARTNERSHIPS

STRATEGIC OVERVIEW

Goals of this Section:

1. Highlight strategies for building and sustaining partnerships to better address intimate partner violence (IPV) and perinatal depression (PD)
2. Provide examples of potential partners, especially non traditional partners, and how they may help you address IPV/PD

Collaboration and coordination linkages with state and community stakeholders are necessary for improving systems of care at the community level. Within each community there is a system involving a broad array of public and private agencies that work at different levels in the delivery of perinatal health care. It is important for community-based programs to receive support from and be linked to state and local perinatal systems of care to contribute to each system's goal of addressing disparities in perinatal health. Building and sustaining partnerships at the state and local level is important for this collaboration and coordination to be successful! There are 3 key components to building partnerships:

Community Partnership. Relationships between the community-based program and external (or potential) stakeholders.

Shared Responsibility. Partners must have a shared responsibility and give what they can, when they can to grow and support the relationship. Over time there often comes increased responsibility, accountability, and increased share of financial resources.

Commitment. Partners must commit to what they are able and willing to do to support the relationship and help make the work successful. It should be clear (in writing) and through regular communication what each partner is committing to do. These commitments should be reviewed and updated on a regular basis.

Building partnerships in the communities they serve is integral to the success of community-based programs.

Community-based programs are a valuable and trusted resource but often the health and well-being of families and children reach far beyond the health needs addressed by one agency. Understanding family involvement and interactions with communities will assist you with identifying potential partners. Partnering with organizations or agencies that provide services to the families you serve provides an opportunity to collaborate, integrate and leverage efforts. Forming partnerships with these types of organizations in the community can help you reach an entirely new group of families who may be experiencing intimate partner violence and/or perinatal depression. Additionally, it gives your organization credibility and helps with buy-in if the community sees your organization partnering with already trusted/known organizations. By working together, organizations can help fill in the gaps and ensure families are receiving coordinated, comprehensive and ongoing services.

Community partnerships can help in the achievement of organizational goals. Resources are limited and not every organization will be able to or is specialized to meet all the needs of a family. By working together, combining talents and resources, organizations are able to more fully provide the community supports needed for families experiencing IPV/PD.

There are many additional benefits to partnering which include the ability to pool resources, expand the reach of limited resources, and increase efficiency by avoiding a duplication of efforts and decreasing the burden on organizations and consumers to go to multiple places for information and services. Integrating and coordinating services related to screening, referral, and treatment of IPV and PD with other partners can be extremely beneficial. Partners can provide expertise in areas that might not be as strong in your organization such as funding/ grant-writing, volunteer coordination, marketing, or experience working with women affected by IPV/PD.

As community partners get to know one another, opportunities to share resources, skills, best practices and lessons learned become more apparent. Partners can cross-train staff by educating each other about their work; provide referrals to partners, and collect and share data across a partnership to support the case for increasing funding or continuing work on IPV/PD.

This section lays out 4 steps for building and sustaining partnerships: Step 1 Develop Goals and Infrastructure for Partnerships; Step 2 Research and Strategize; Step 3 Reach out to Potential Partners and Market the Opportunities, and Step 4 Sustain the Partnership. Each step highlights concrete tactics as you create a successful partnership.

In order to promote the benefits of community partnerships and win staff support, leaders can:

- Communicate! Create an email or introduce the topic at a staff meeting. The key is to discuss the importance of better addressing IPV/PD and the goals and benefits of a potential partnership.
- Listen! Consider hosting a Directors' Brown Bag Lunch to hear staff questions and concerns regarding implementing efforts related to IPV/PD. Be available throughout the process for additional questions, ideas or concerns.
- Provide Opportunities to Get Involved! Post messages/updates and provide opportunities for collaboration and volunteering related to IPV/PD. Direct potential partners to your website (and other materials and documents) and have your staff learn more about your community partners.
- Open up to Community Involvement! Hold community forums to involve members of the community and attract new potential partners and volunteers.
- Work together with your Staff! Work closely with your staff to develop descriptions of how job expectations may change as new partnerships evolve. Various members of your staff may have existing relationships with partner organizations (through friends or previous work). Enlist champions on staff to help with the work.

STEP 1: DEVELOP GOALS AND INFRASTRUCTURE FOR PARTNERSHIP

As an organization, it is important to plan for the partnership ahead of time. This includes creating a vision and getting leadership and staff on-board with the plan. Use Section 2: Assessing Readiness (pg 26) to lay the foundation for this work.

Agency leadership must make a firm commitment to partnership. Discuss the importance and benefits of a partnership and use talking points from Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression (pg 8) for specifics on the need for partnerships related to IPV/PD.

Obtain staff buy-in and support. Educate managers and staff about the goals for reducing IPV/PD and the goals for partnership, including how the roles and responsibilities of staff may change or be supported by partners.

Use existing consortia to help build partnerships and infrastructure. Existing consortia are vital to building partnerships around IPV/PD in your community. Smaller working groups within the consortium can be tasked to reach out and build new partnerships. The existing consortium will also support the overall vision, values and goals and create strategic plans for developing partnerships around IPV/PD.

Use Tool 1. Establishing an Intimate Partner Violence/Perinatal Depression Work Group (pg 53). Putting your organization's goals, expectations and plans on paper ahead of time will help flush out what the organization is really trying to accomplish, what/who it will need to get there, and what success will look like. This will also help clarify the vision for when your organization will need to convince staff and potential partners of the needs and benefits of the partnership. The types of questions the organization will need to ask itself include:

- What does our organization hope the partnership will accomplish?
- What partners does our organization already have and which ones does it need?
- What are our goals and expectations for the partnership?
- How will our organization define a successful partnership? How will our organization know if it's working?
- What is the plan for growing and sustaining the partnership?
- How will our organization evaluate the partnership? How often will it evaluate the partnership? What changes need to be made and how will they be implemented?

POTENTIAL STAKEHOLDERS AND PARTNERS (INCLUDING NON-TRADITIONAL PARTNERS)

- Community Health Centers
- Hospitals
- Universities/Community Colleges
- Mental Health Services
- Community/Recreational Centers
- Intimate Partner Violence Organizations
- Substance Abuse Treatment Centers
- HIV/AIDS Organizations
- Family Planning Agencies
- Law Enforcement and the Judicial System
- Home-visiting programs
- Health Departments
- OB-GYNs and Pediatricians
- Other Private or Non-profit organizations including advocacy and policy organizations State Title V MCH Program
- Medicaid
- Children's Health Insurance Program (CHIP)
- Shelters
- Head Start and Early Head Start Programs
- YWCA, YMCA
- Schools, After-care, and Daycare Centers
- Unemployment Centers
- Faith-based Institutions
- Welfare Assistance Agencies
- Elected Officials
- Volunteer Organizations
- Businesses/Employers (e.g. laundromats, hair salons, grocery stores, restaurants)
- Federally-Qualified Health Centers
- Indian/Tribal Health Services
- Managed Care Organizations
- Child Protective Services
- The United Way
- Local Funding Organizations
- Citizens of the Community
- Local and State Media
- Transportation (e.g buses, taxies, metro/railway)
- Food Banks

STEP 2: RESEARCH AND STRATEGIZE

Once your organization has set the stage it is time to start the process of researching potential partners and reaching out to them.

One of the big challenges can be ensuring the creation of a partnership that includes not only representation from organizations but also community members. Your organization will want the voice of consumers in the community who will be utilizing the services to determine the needs, barriers, cultural ideals and opportunities to implement new initiatives. Finding members of the community to serve (and be active, full participants) on the community consortium can be a challenge for many organizations, but it can be done and can often determine the level of success for the subsequent work done. Consider holding meetings later in the day to accommodate consumer schedules. Your organization may also choose to offer incentives (i.e. food, transportation vouchers or childcare). Your organization may decide what type of incentive would be best given the population, community and available resources.

When identifying new partners it is important to consider and reach out to non-traditional partners. These partners may not be aware that their organizational mission coincides with yours, impacts the same population, or provides different services for the same population. Examples of nontraditional partners are law enforcement, the judicial system, faith-based organizations, large for-profit companies, or schools/daycares. Non-traditional partners can be particularly useful for cross-training staff , employing the population served and reaching additional women and families with your message and services. Along these lines, the organization will want to ensure that key leadership within the community is represented. This might include members of a school-board, city council, or leaders of hospitals or other organizations.

When identifying partners consider the type of linkage this will be: service or systems based. For example, partnering with the local faith based organization can help reach your target population and provide a venue for services (service-based linkage). Partnering with State Title V MCH, Medicaid, and Children's Health Insurance Programs (CHIP) will assist with issues related to care coordination, insurance coverage, and access to care (systems-based linkage). State domestic violence coalitions and perinatal depression networks can provide important information by sharing existing data, research, campaign materials, and experiences, as well as help coordinate your message and care delivery within the state-based system. Systems-based linkages are the foundation that is needed to make service-based efforts possible and successful. Both types of partnerships are needed in order for your work to be successful.

To begin strategizing, think about:

- How can our organization build partnerships that focus on prevention of IPV/PD? Consider who in the community works to alleviate the burdens and stressors that put women and families at risk for IPV and PD.
- How will our organization reach out to the community and raise awareness about IPV/PD? Who might be helpful partners in this effort?
- How will our organization make women feel comfortable in taking advantage of screening, referral and treatment related to IPV/PD? Who might be helpful partners in recruiting and referring women?
- Who else in the community works with the target population and how can a partnership help increase outreach and recruitment?
- What potential partners could help prepare our organization for dealing with inquiries and increased attention when addressing IPV/PD in the community, especially when conducing raising awareness campaigns?
- What potential partners might be able to provide screening and treatment?

Questions to ask when identifying potential partners.

- Which stakeholders have an interest in the partnership that your organization is planning?
- Who might be willing to join this collaboration?
- Are potential partners willing to share their resources and capacities?
- How do the interests of each potential partner fit into the broader collaboration?
- Does our organization trust and respect the work and staff of each potential partner?

(Fiester, 2004)

- What potential partners could provide referrals to our IPV/PD services?

Do you need a partner who will:

- Help alleviate the burdens and stressors that put women and families at risk for IVP/PD -› social service agencies, shelters, unemployment services, non-traditional partners?
- Help to identify and fill gaps in screening and assessment services for depression and intimate partner violence -› health care providers, community based health centers, social service agencies?
- Enhance or support activities for community-based interventions and services that are culturally and age appropriate -› community NGO partners, nontraditional partners, social service agencies?
- Help increase the capacity for physicians to recognize and treat depression or intimate partner violence -› hospitals, universities, physicians, nurses, social workers?
- Help to develop infrastructure in your community to coordinate screenings and referrals for treatment -› providers who will be a part of the referral network, staff, consumers?
- Raise awareness in the community about the signs and effects of depression and intimate partner violence and where to go for help -› local media, non-traditional partners, social service agencies, local businesses?
- Collect data to support your case -› providers within your referral network who can keep track of beneficial information (e.g. number of referrals made, number of women seen for IPV or PD, number of referrals to outside partnering organizations etc.)?

Strategies for Identifying Potential Partners:

Often the snowball approach is the best way to identify potential partners. By starting with one or two potential leads from co-workers, friends or family members, your organization will quickly learn who or what organizations have an interest in family welfare or IPV/PD. After speaking to people you will likely receive more and more names and leads to follow—hence the snowball approach. Starting with people you already have a relationship with is usually the easiest strategy KU Workgroup for Community Health and Development, 2010). Alternatively, start to research organizations in the community and begin visiting, calling or emailing them to introduce yourself and the work your organization is doing. Get involved in the community by attending cultural and community events. You may meet potential partners at such events, as well as future clients. Finally, look for existing local, state and regional networks addressing IPV/PD. Many states have existing perinatal networks and coalitions for domestic violence. Please refer to Tool 1. Example of a Referral Care Pathway Model (pg 119) for a more in depth description of how referrals and services can be provided with community partners.

To help you identify potential partnerships in your community, use Tool 2. Community Resource Inventory for Recognizing Potential Partners, continued (pg 56). As you use the tool and think about potential partners, ask the following questions to guide your thoughts.

Questions to Ask Before Pursuing a Potential Partner:

- Does your organization and your potential partners share the same organization goals and mission?
- Who is affected by the problem at stake? (e.g. consider mothers, fathers, children, grandparents, neighbors, friends, employers/employees and all organizations)
- What are the benefits of this partnership? What do they gain by helping us? What do we gain by partnering with them?
- Would this partnership be long or short term? (e.g. does the organization need their assistance for a one-time event or would it like their support for years to come?)
- What would be the potential cost or limitations to sustaining the partnership (e.g. if approaching an elected official, when their terms ends what's next?).
- What are the risks?

Addressing Stigma through Partnerships

Due to the stigma often associated with IPV and PD, many people and organizations might feel uncomfortable or ill-equipped to address IPV/PD. These are precisely the types of organizations with whom your organization should form a partnership. As organizations and people talk more and learn more about IPV/PD, their comfort increases and stigma is

reduced (Penn & Couture, 2002). Furthermore, many of the consumers and families your organization is targeting will have preconceived notions about IPV and PD, and may be unwilling to seek help or utilize your services. By working with non-traditional partners, in locations where your target population already is, your organization can help explain the potential partner's connection to IPV/PD and how they can help address it. Creating awareness and addressing the stigma associated with IPV/PD will help improve your organization's reach, services, and results. Please refer to Section 4: Raising Awareness (pg 62) for more information.

Focusing on Prevention through Partnerships

Prevention of IPV/PD is generally a priority of any IPV/PD initiative. Many of your organization's potential partners will be those organizations (often including non-traditional partners) who are doing work that can alleviate the burdens and stressors which put the target population at risk for IPV/PD. Approaching such organizations from the perspective of how their services is connected to the prevention of IPV/PD (e.g. alleviating stressors) will increase the likelihood of organizations to collaborate with your efforts. Partnerships which focus on prevention may help each other by raising awareness of IPV/PD and cross-promoting each other's services.

Partnering with State Level Agencies:

For a community-based program it can be especially helpful to partner with State level agencies that can help improve systems-based linkages. Reaching out and working with State Title V MCH, Medicaid, and Children's Health Insurance Programs (CHIP) will assist your organization with issues related to care coordination, insurance coverage, and access to care. These are the foundations for service-based efforts to be successful. Additionally, State level agencies are often the ones most involved with policy decisions and can influence and affect legislation in your state. By working more closely with them, your organization's voice and needs related to IPV/PD can be heard more strongly.

STEP 3: REACH OUT TO POTENTIAL PARTNERS AND MARKET THE OPPORTUNITIES

Oftentimes the most difficult part is finally taking the leap to reach out and make your case. But of course, this is a necessary step if the partnership is going to succeed!

As an organization, you will likely need to send a representative or small team that is able to work with the potential partner. You will need to decide what staff level of the organization is necessary for this step (executive level versus community level staff). It is best to nominate someone who is passionate about addressing intimate partner violence and perinatal depression, knows the topic well, understands your organization's mission and values, and understands and can articulate how this partnership will be mutually beneficial.

Some general steps include:

- Identify a point of contact in the potential partner organization. Who will you target within the organization (leadership, community level staff or both)? Set up a meeting (either by phone or email). When possible, have a staff member, mutual friend or colleague make an introduction. This will lend inherent value/credence to your proposal.
- Now that a meeting has been set up, do your homework. Research the organization, the work they do, their target population, and even who their funders are. Find out about the leadership in the organization and other key staff. How will your organization's mission of addressing IPV/PD fit in with what the organization is already doing? Who are they already working with? What services or resources do they already offer?
- Research target person/persons. Do some homework about the person you will be meeting. What do you know? And what can you find out?

PROGRAM HIGHLIGHT

State: Iowa
Program: Des Moines Healthy Start, Visiting Nurse Services of Iowa
Website: http://www.vnsdm.org

Finding Unlikely Community Partners to Overcome a Challenge

The Des Moines Healthy Start Project experienced an influx in their refugee populations which created a challenge to providing services. To address the cultural and linguistic challenge the program partnered with local leaders in many of the different refugee populations, eventually hiring some of them to their staff. These partnerships helped the program better understand the cultures, the challenges in reaching families experiencing IPV and PD, cultural norms and stigmas, and helped bridge the language and culture gap. These new community partners help bring refugee families in who were skeptical or unsure about the American health care system and services offered. This also allowed the program to adapt many of their educational materials and questionnaires to be more culturally appropriate. The program attributed their success in working with refugee populations to their established partnerships.

PROGRAM HIGHLIGHT

State: North Carolina
Program: North Carolina Healthy Start, Baby Love Plus
Website: http://www.nchealthystart.org

Finding Unlikely Partners within Your Community

In North Carolina, the Baby Love Plus Healthy Start project and State Title V program work together to meet their goals and reach their target population. Because of the vast geographic area covered by this Healthy Start program, it is important to form strong partnerships across the State in order to be successful. Some of these partnerships include faith-based organizations (churches and faith-affiliated organizations). These partnerships not only help the program reach a greater number of women and build trust for women and families to seek services, but they also serve to improve the Healthy Start program itself. The program uses these partnerships to pilot materials and programs, get feedback, and use these forums to provide training and technical assistance. The Healthy Start project has partnered with local barbers, beauticians and community volunteers to create a Lay Health Advisor program (LHA). Lay Health Advisors are trained to provide appropriate maternal child health and related information to women of childbearing age. In turn, they conduct outreach and client recruitment activities and link pregnant and postpartum women to Healthy Start (Eastern Baby Love Plus) local health department partners for enrollment in perinatal health services. The LHAs are able to help reach women and families across key areas of the State in ways that would be too difficult for the Healthy Start staff alone. It has also been a great experience for the lay health advisors themselves. These partnerships have allowed this Healthy Start project to expand representation of stakeholders on their consortium and to build the capacity of their partners. With more limited resources, they have been able to move past simply financial partnerships and instead exchange services and support.

What is their background, their work position, their special interests? What have you observed, or what can you learn about their personal style, or way of doing business? The more you know in advance about your potential partners, the better you will be able to present your case so that it will meet their needs, and in a manner they can easily hear and appreciate.

- Develop an outline of opportunities. Put together a list of opportunities and ways in which the two groups can work together to reach a common goal of reducing IPV/PD. Consider how this partnership will be mutually beneficial and be sure to highlight the specific benefits to the potential partner. Why should the target person want to or be willing to do what you are asking? Be aware of those benefits in advance, and be able to present them without being asked.
- State what you are looking for from the meeting. Be explicit.

  Does your organization want the potential partner:

  – To come to one of your meetings?
  – To serve on a board, or advisory board?
  – To undertake a specific task (alone, or with a task group of yours)?
  – To write a check?
  – To make some other kind of gift, or donate an in-kind service?
  – To recruit others to your organization, by acting as intermediary?
  – To participate in a Referral Network?
  – To get involved in some combination of the above?
  – Something else?

If there is one specific thing your organization wants, don't hesitate to ask for it directly. But, it may be that you don't want one specific thing. You may be hoping instead that the prospective partner will contribute or participate in any of several possible ways. In that case, you might say something like: "Here are several ways you might be able to help us. Which of these might make sense for you?" In other words, you give the potential partner some options. Offer a menu ("menu technique"), with several different "courses" to choose from.

- Listen to the potential partner. Address any questions or concerns the potential partner may have and try to discuss how they might be alleviated. Often times concerns are related to limited time or resources, so be sure to address what kind of commitment your organization is looking for and what will be asked of the partner.

  The last step in your discussions is to reach agreement and close the deal, if there is one.

  – Commitment to a particular course of action. The best kind is a commitment to a particular course of action. For example, the partner agrees to endorse your IPV/PD awareness program, participate on the consortium, become a provider in the referral network, or to lend its name to an ad in the paper.
  – Agreement on general values or goals. If you can't get an action commitment, then you can agree on some general values and goals. The partner says, "We will work toward reducing intimate partner violence and perinatal depression in our community."
  – Agreement on principle. If you can't get that far just yet, another variation is to "agree in principle" on a general framework, from which details of agreement can be worked out later. More talk will be necessary, but even getting this much agreement (in some cases) can mean you have come a long way.

- Bring along fact sheets/brochures/supplementary materials/reports/ business cards. This will help make your case and leave your potential partner with some take-away information. This is especially helpful if your potential partner does not have very much knowledge about the intersection and importance of addressing IPV/PD.
- Accountability. Have in mind how you plan to hold your organization and the potential partner accountable and discuss this agreement (i.e. roles/ responsibilities, MOU, contractual agreements). Please refer to Tool 3. Sample Memorandum of Understanding (pg 57) at the end of this section.

STEP 4: SUSTAIN THE PARTNERSHIP

Sustaining partnerships can be a difficult task. The steps to take to sustain a partnership are similar to what one might do when working to sustain any relationship or friendship.

Regular communication and meetings. It is important to maintain regular communication via phone, email, and in-person meetings. Make a note in your calendar, even once a month, to send formal updates or even informal check-in notes to your partners. Regular communication helps keep both partners on track.

- Hold regularly scheduled in-person meetings
- Communicate via email and phone in-between meetings
- Offer regular, formal reports for all staff involved
- Complete work in sub-committees when appropriate

Invite partners to events. If your organization is hosting or attending a community health fair, be sure to invite your partners. This shows that you value their support and partnership and will help grow the relationship.

Update goals for the partnership. Just as any friendship or relationship evolves, so too will the partnership. It is important to update the vision and goals, especially if one of the organizations undergoes any major changes. Meeting and communicating regularly can help ensure that this occurs.

Be flexible to change. As your organization and partners grow, what you can offer and what you will need from the partnership will also change. Be flexible and willing to make changes to your agreements and plans based on changes to your organization, staffing or funding. Be willing to work with partners as they experience changes. In this tough economic climate, being understanding of financial changes can be very important and further highlights the need for such partnerships. In times of limited resources, partnerships are vital to success!

Move past monetary support. Partnerships must adapt to the changing economic climate and needs of the target population. In many cases, moving past simply providing partners with monetary support is critical. Consider offering technical assistance, trainings, or resources and gifts such as water bottles, pedometers or other incentives and materials you might already have on hand. As a partnership grows, it must be based on more than just financial incentives and move toward a mutually beneficial and true commitment to the cause.

Record statistics. Keep track of information that can help lend evidence to the need, success and outcomes of the partnership. Your organization may want to record referrals made to your partners, referrals coming from your partners, new patients, or attendance at events and meetings.

Market the work done by the partners. The community won't know the resources are there unless you promote your efforts and/or organization. By cross-promoting with partners you can both help to get your message out and increase awareness. Consider inviting unconventional partners such as grocery stores or coffee shops to help with events and marketing. You can also help support each other's endeavors, for example, by providing letters of support when needed for funding opportunities.

You can also increase awareness of the public health burden of IPV/PD by using the information from Section 4: Raising Awareness (pg 62) of this toolkit.

Find opportunities to share resources. More and more funding sources are requiring collaboration. Look for opportunities to apply for jointly funded projects. If your organization doesn't want to share funding directly, look for ways that you can be mutually beneficial to each other. Plan to hold a joint staff training so that clinical staff understand what social workers at the local women's shelter do, and vice versa.

Building partnerships in your community can be extremely beneficial when addressing IPV/PD. There are several steps to creating and sustaining partnerships, including: developing goals and an infrastructure, researching and strategizing how to reach out and identify potential partners, and successfully connecting and maintaining a partnership through continued communication and collaboration. The box to the right highlights the characteristics of a successful partnership. In addition, there are several tools and resources highlighted here which can assist your organization in following the steps towards successful partnership building.

Characteristics of Successful Partnerships

1. Purpose
    - Clear and common goals based on mutual benefit and understanding of individual goals and motivations
2. Process
    - Understanding and consulting stakeholders
    - Clarity of roles and responsibilities
    - Understanding resource needs, capacities and constraints of all the partners
    - Communication – regular, open, and transparent, with accountability structures for joint decision-making and conflict resolution
3. Progress
    - Evaluating and celebrating success
    - Continuous learning and adaptation

(Nelson & Prescott, 2005)

TOOLS AND RESOURCES

The Community Tool Box

Website: http://ctb.ku.edu/en

The Community Tool Box provides additional information about building and sustaining partnerships and coalitions.

Office of Partnerships and Grant Services

Website: http://ctb.ku.edu/en

The Office of Partnerships and Grant Services home page (Government of the District of Columbia) offers guidance on creating partnerships for grant purposes, with links to other materials on evaluating and improving collaborations.

Community Anti-Drug Coalitions of America

Website: http://www.cadca.org

The Community Anti-Drug Coalitions of America page provides a "Coalitions Toolkit" that addresses policy, working with the media, funding, and other items to help coalitions succeed.

State Domestic Violence Coalitions

Website: http://vawnet.org/links/state-coalitions

Domestic violence coalitions help connect local domestic violence providers in states and territories, and provide valuable resources about state/territorial services, program and policy. To find information about state and territory domestic violence coalitions, you can visit the links to each individual coalition on the VAWnet (National Online Resource Center on Violence Against Women). The state coalition pages list local shelters and domestic violence agencies within their state.

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

Tool 1. Establishing an Intimate Partner Violence/Perinatal Depression Work Group

A work group can become an extension of any partnership formed. By bringing together all partners your organization can work together to problem solve and share resources. This document can help to clarify your goals, identify partners, establish and build on the partnership, evaluate the results, and operationalize the findings into your efforts. As an organization you will need to decide which individual is best to complete this document or if this should be done as part of a team effort.

1. What do we hope for the work group to accomplish; what is the goal? *(For example, identify and resolve issues with screening and referral for IPV/PD or identify a network of referral resources to assist families experiencing IPV/PD)*

   GOAL:

   _____

   _____

   _____

   _____

2. How will we know we are succeeding? What measures of success should we use? (*For example, hold 2 joint training sessions on IPV/PD for all partners)*

   _____

   _____

   _____

3. What partners do we already have that can help us accomplish this goal? *(For example, mental health providers in the community, women's shelters, faith-based organizations, etc.)*

   _____

   _____

   _____

4. What partners do we need to help us accomplish this goal?

   _____

   _____

   _____

5. How could you reach out to these partners? *(For example, are their community events and opportunities to connect with potential partners)*

   _____

   _____

   _____

6. What do we offer to the partnership? *(For example, what resources, expertise or services do we have to offer that will make this partnership a win-win for all parties involved)*

_____

_____

_____

7. What are the expectations and commitments of each partner? *(For example, one partner will donate 10 hours of labor or a certain dollar amount)*

_____

_____

_____

8. How will we maintain regular communication with partners, and what type of communication will we use? *(For example, hold conference calls once a month with all partners)*

_____

_____

_____

Evaluation of the Partnership

At specified points in time (e.g.,1 month, 3 months, 6 months, 1 year, 2 years), evaluate how the partnership is working. This will ensure that you are both on the same page, that the partnership is mutually beneficial, and can help you to make necessary changes early on if needed.

1. Does the partnership meet the goals and expectations we initially set? How so?

   ☐ Yes ☐ No

   If yes, what has been successful in meeting the goals/expectations?
   If no, what changes are necessary for meeting the goals/expectations?

   _____

   _____

   _____

2. What are strategies for improving the partnership, or how will you implement necessary changes? *(For example, will you need to improve communication, meet more regularly, increase staff commitment/buy-in, promote/market your services and partnership within the community, or expand your network of non-traditional partners?)*

   a. _____

   b. _____

   c. _____

   d. _____

Tool 2. Community Resource Inventory for Recognizing Potential Partners

Brainstorm potential partnerships by filling out the chart below. Each row suggests a specific type of partner to consider, and the columns provide questions to answer as you think through the pros and cons of each potential partnership.

Where to Look for Partners	Potential Partners	What Are They Doing? (Or what could they be doing?)	Benefits and Goals for this Partnership	Potential Risks for this Partnership	Is this a Beneficial Partnership to Pursue or Sustain?
Who is already working on the issue of IPV and PD in your community?					
Local Medical/Health related Agencies					
State Level Agencies					

Where to Look for Partners	Potential Partners	What Are They Doing? (Or what could they be doing?)	Benefits and Goals for this Partnership	Potential Risks for this Partnership	Is this a Beneficial Partnership to Pursue or Sustain?
Non Traditional Partners within Your Community					
Partners of Your Own Group, Colleagues, and Friends – Who Do I already Know?					
Others					

Tool 3. Sample Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING (MOU)

between

_____ [insert name of Party A] and

_____ [insert name of Party B]

This is an agreement between "Party A", hereinafter called _____ and "Party B", hereinafter called _____.

I. PURPOSE & SCOPE

The purpose of this MOU is to clearly identify the roles and responsibilities of each party as they relate to....

In particular, this MOU is intended to:

Examples:

- Enhance
- Increase
- Reduce costs
- Establish

II. BACKGROUND

Brief description of agencies involved in the MOU with mention of any current/historical ties to the organization.

III. [PARTY A] RESPONSIBILITIES UNDER THIS MOU [Party A] shall undertake the following activities:

Examples:

- Develop
- Deliver
- Share
- Support
- Provide
- Promote
- Refer
- Review
- Comply
- Train
- Maintain records
- Sponsor
- Evaluate

IV. [PARTY B] RESPONSIBILITIES UNDER THIS MOU [Party B] shall undertake the following activities:

Examples:

- Develop
- Deliver
- Share
- Support
- Provide
- Promote
- Refer
- Review
- Comply
- Train
- Maintain records
- Sponsor
- Evaluate

V. IT IS MUTUALLY UNDERSTOOD AND AGREED BY AND BETWEEN THE PARTIES THAT:

1. Review and Modification

2. Termination

VI. FUNDING

This MOU does (does not) include the reimbursement of funds between the two parties.

VII. EFFECTIVE DATE AND SIGNATURES

This MOU shall be effective upon the signature of Parties A and B authorized officials. It shall be in force from Date to Date. Parties A and B indicate agreement with this MOU by their signatures.

Signatures and dates

[insert name of Party A]

_____ Date: _____

[insert name of Party B]

_____ Date: _____

NOTES PAGE

NOTES PAGE

Section 4

RAISING AWARENESS

STRATEGIC OVERVIEW

Goals of this Section:

1. Describe what raising awareness is and why its important for an organization's IPV/PD initiative
2. Provide tips for creating a successful IPV/PD awareness campaign
3. Highlight strategies and medias to use for raising awareness

There are several guides for raising awareness about social issues. Raising awareness around intimate partner violence (IPV) and perinatal depression (PD) as co-morbidities is important for reducing the stigma associated with both as individual issues, and as contributing factors to each other. It is important to educate health professionals and members of the community on the impact of IPV/PD to health and available services in the community.

Raising Awareness: The goal of awareness-raising activities is to build understanding in the wider community, to highlight your work and its importance, and to persuade others to become involved as concerned individuals, allies and activists themselves. The main goal is to educate people so they can make informed decisions.

The tools and strategies in this section can be used for raising awareness in the community about the importance of addressing intimate partner violence and perinatal depression. When setting up your organization's strategic plan, you will be able to identify your goals as pertaining solely to raising awareness.

The best time to plan for an awareness campaign is after direct experience or preliminary research, when your organization has the capacity to carry it through, and when you have the enthusiasm and energy to complete it. Your strategic awareness plan should include resources, assets, specific goals targets, and appropriate tactics. You must be prepared to handle an increase in interest and attention when placing your organization as publicly knowledgeable on IPV and PD. The plan must also be flexible, so that it may adapt and change to the situation as necessary. Section 6: Policy (pg 96) can assist with determining the political climate or priority areas in your city or state. In addition, please refer to Section 3: Partnerships (pg 40) for identifying partners that may be able to provide support to your campaign, and ways of solidifying and leveraging partnerships.

Steps For Creating a Successful IPV/PD Awareness Campaign:

1. Get Informed on the Issues of IPV and PD
2. Develop a Strategic Plan
3. Put the Plan into Action

STEP 1: GET INFORMED ON THE ISSUES OF IPV/PD

Research and learn as much information on the issues of intimate partner violence (IPV) and perinatal depression (PD) as possible. This includes the ways in which they intersect and counter arguments to their importance. Please refer to Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression (pg 8), for background information and statistics as well as information concerning laws in your state that cover domestic violence and child protection. Research is necessary because it provides substance to your cause, adds credibility, and ensures your organization is complying with state laws regarding IPV. It will also provide new information to assist you in making your case. It is important to have a comprehensive understanding of the issues to develop a plan of action for the awareness campaign. This knowledge will come from detailed research. Be sure to fact check. Be skeptical about sources - many websites offer their own collections of resources, or summaries of research that have already been conducted. These can be extremely helpful tools for getting informed about IPV and PD. Helpful questions when fact checking may be: Do the statistics cited make sense? Are these organizations partisan or unaffiliated with a political party or agenda? What are the potential motivations or goals of the individuals conducting and sharing this research and what is their background? Are there conflicts of interest or reasons to be leery of the information they are sharing?

Think about what questions you, your colleagues, and/or staff have about IPV and PD and would like to have answered. Does your community have the capacity to support IPV/PD efforts (e.g. providers, services)? What observations exist from your work relating to IPV and PD? What are the stigmas and barriers your organization and clients experience related to IPV/PD? Are there culturally specific barriers to reaching women and families in your community? What might prevent or encourage women to seek assistance for IPV/PD? What do you hope to teach the community about IPV/PD? Think about the types of information that you will need: personal interest stories and experiences, statistics (local and/or national), and academic research.

Identify sources of information to help find answers to your questions, such as clearinghouses of information, epidemiological studies, journals, etc. Internet resources are excellent for gathering information. Additionally, information can be gathered from newspapers, policy reports and papers, journals, and informational presentations. Other organizations are a good source of information as well, whether they are advocacy organizations or providers. Make sure to have a full understanding of the current policy issues.

Go through the resources in an organized fashion. Make sure to keep a list of the resources used to educate yourself and their citations, as these can become helpful tools when sharing this information with others, publishing information through media sources or giving interviews, and posting resources on a website. Tool 1. Plan of Action for Raising Awareness (pg 77) for examples of how to organize the resources found.

List your organization's assets by conducting a brainstorming session with other team members to develop a list of resources and assets that you may already have. Do you already have an organization website with a resource list that could be expanded? Do you already conduct sensitivity or awareness training for law enforcement or prosecutors that could include a session on IPV and PD? What partners do you already have and how might IPV/PD work fit in with those existing relationships? What about staff/team member expertise? Does your organization have a volunteer network that could be utilized? Is there a nearby library or university that will be helpful in conducting research and learning about the issue?

Identify Stakeholders and ask others for assistance such as activists, academics/experts, librarians, and journalists. Please refer to Section 3: Partnerships (pg 40) for help with identifying key stakeholders. When asking for assistance and digesting resources identified, keep in mind that others may have already done this kind of research, so you do not need to re-create the wheel.

How to Make the Most of Limited Resources

While raising awareness campaigns often require financial resources, there are many activities and existing resources that do not. Partnering with organizations, exchanging services or trainings, utilizing volunteers, or acquiring local sponsorship for activities can lessen the need for financial resources. Articles or interviews with local media require some time, but are inexpensive ways to spread your message. Additionally, there are existing resources (examples throughout this section) that provide free posters and awareness materials. Remember, you do not need to re-create the wheel. If you don't have the time or resources to develop a completely new and innovative campaign, consider borrowing existing materials and ideas from successful campaigns that are happy to share their message.

STEP 2: DEVELOP A STRATEGIC PLAN (SET GOALS AND IDENTIFY TACTICS)

Brainstorm with your team the types of raising awareness tactics and techniques that are best suited to your goal and what you are able to do given limits of time and money. There are several strategies for conducting raising awareness campaigns. Be creative and diverse when developing the message you want to cultivate.

Establish the goal or message of your raising awareness campaign. What does success look like? Would you like to reach out to a certain number of community members? Conduct a specific number of events or trainings throughout the next year, with a target number of participants? Would you like to raise enough money to conduct a local media campaign?

Try to set goals that are realistic and attainable. The goal should also be measurable so that you can make practical, focused adjustments throughout

your campaign if necessary as well as congratulate yourself when your goals have been reached! Setting measurable, attainable goals makes it easier to increase support and encourage all teams members involved in the campaign.

It may be helpful to set smaller targets within your broad goal. This may facilitate responsibility sharing and leadership development throughout your team. Breaking down your goal into smaller, incremental steps helps team members stay motivated, and allows for greater transparency and responsibility throughout the progression of your campaign. Giving someone

responsibility to lead an activity may also make them more likely to buy-in to the activity and end-goal. Utilize Tool 1. Plan of Action for Raising Awareness (pg 77) for an example of how to organize and measure your goals.

Identify your target audience. Do you want to raise awareness among clients and/or their families, healthcare providers or community partners? Would you like to raise awareness about the intersection of IPV/PD among community members in general?

Once the focus and audience of your campaign has been identified, try to envision the needs and influences of each audience member. Identifying such descriptive items will ensure that the tactics utilized have the best chance of success. Understanding your target audience will also help you adapt the language and message to have the most impact on your chosen audience. For example, the messages and approach targeting providers, law enforcement, and families will differ based on your intent, goal and role they play in addressing IPV/PD. For messages to the general community, it is best to write them at a middle school reading level, using culturally and linguistically appropriate scenarios that are familiar to the community. For each target audience, think about why they would be interested in addressing IPV/PD—what's in it for them?

Know your audience.

Understanding how to engage your audience is key in the development of a cohesive message. Your message must reflect the needs and language of your audience; this will make your message more persuasive. Involving members of the target populations in the development of your messages will increase acceptability.

Community leaders may prefer sound-bite information. They may also be interested to hear of

Common Raising Awareness Tactics:

- Write articles about IPV and PD, what it is, why it is important, and that resources are available.
- Write an article for a parent magazine on the intersection of IPV/PD and effects on the child.
- Create a media campaign with local news channel advertisements or public transportation ads.
- Conduct interviews with local or state level media outlets.
- Organize local events and advertise using local media.
- Co-sponsor events with other community groups.
- Conduct trainings or meetings with established (and potential) partners.
- Set-up an informational booth at local health fairs with the main topic being the relationship between IPV and PD.
- Participate in other issue-awareness programs, campaigns, and panels in the community.
- Incorporate IPV/PD information into your organizational website, create a website, or link to other resources and websites.
- Utilize traditional print media (newspapers, magazines, poster campaigns) and radio messaging.
- Utilize social media sites including Twitter and Facebook.
- Engage with survivors in your community if they are comfortable doing so. Their voices and experiences can be instrumental in successfully raising awareness.

potential savings generated by a program or initiative to be supportive.

The general public may prefer plain language. When engaging the general public, is it useful to discuss the costs to society (including financial and social costs).

Identify the campaign strategies and select an appropriate method of engaging with that audience. For instance, leaders may respond well to factual information that is put before them. Keep in mind the influence of statistical information. Or, perhaps you find that the resources at your disposal lean heavily in favor of telling personal interest stories, and feel your target audience would respond best to this type of information. You may find that conducting interviews with local media outlets or networking with your target audience by attending community events is the best way to allow individuals to tell their story.

There are many different ways of defining your goal and employing different tactics for meeting that goal. Please refer to Tool 1. Establishing an Intimate Partner Violence/Perinatal Depression Work Group (pg 53) at the end of this section, for ideas. Keep in mind that the tactics used must also work within the constraints of the resources and assets identified in Step 1. Perhaps time, money, or staff is limited. You may find that reaching out to media outlets and holding events are time consuming. Perhaps an awareness campaign through social media sites fits your needs best, as staff can easily take 10-15 minutes a week to contribute to these efforts. Developing partnerships is a strategy for alleviating some of these costs. Please refer to Section 3: Partnerships (pg 40). Try working with local businesses and media to develop a cost-effective and mutually beneficial IPV/PD awareness campaign.

When planning your awareness tactics, make sure to identify the amount of time, money, and effort needed to accomplish each goal. It may also be helpful to hold a specific committee or team member responsible for implementing different goals or tactics within your campaign. What matters most is selecting strategies that work best

Create a Poster or Radio Campaign

Posters are an easy way to get your message about IPV/PD out into the community. Use them in your own office and distribute them to partner organizations and local businesses. If you don't have the resources to create your own from scratch, there are many available for order at a low cost (or even free). It is important to remember that posters and materials should be culturally competent and include women/families of the same race/ethnicity as your target population. Here are just a few examples:

The Avon Foundation provides free domestic violence awareness posters at: http://www.oconnordvposter.com

The National Center for Domestic Violence provides a variety of awareness materials and posters at: http://ncadv.org

For examples of high impact posters, please refer to Minnesota Center Against Violence and Abuse: http://mincava.umn.edu/documents/mwc/mwc.html

The New York State's Office for the Prevention of Domestic Violence at: http://opdv.ny.gov/publications/download.html

Radio is also an effective way to distribute your message. Partner with your local radio station and create a short public service announcement. For an example, visit the Women's Center and Shelter of Greater Pittsburgh's to listen to a radio announcement at: http://www.wcspittsburgh.org/

for your organization and team. There are many different ways to be successful!

STEP 3: PUT THE PLAN INTO ACTION

Craft the message using information collected in the research phase.

It is important to develop and craft the message your organization wants to communicate. Ideally, you want to be able to deliver your message about IPV/PD in a few brief sentences. Focus on being able to briefly identify the problem (e.g. the intersection of IPV/PD), explain the consequences (e.g. health consequences for the woman and on her family/children), and propose a solution (e.g. What services do you offer and how can women access them in your community? What does a screening entail? What does treatment entail?). Develop a coordinated message that brings together policy points, key phrases, and other relevant information. Employing consistent wording increases the effectiveness of your message.

Working with state domestic violence coalitions can offer support in crafting a consistent, accurate message for your community. Several coalitions currently engage with the media and have created talking points and communication plans that may be helpful for your organization.

You may have already identified a particular message during the "setting your goals" phase of Step 2. Crafting your message is a detailed step where you and your team focuses on the specific language and wording used in your message, or creates a list of detailed talking points for upcoming interviews, or translates the message in different languages for your different target audiences. When crafting the message in Step 3, your team should develop a specific message briefly explaining what IPV and PD is, how they are related, a relevant statistic of the scope of IPV and PD in your community, and exactly what steps your target audience can take to help. Sometimes it is helpful to develop an "elevator pitch"

Raising Awareness to Reduce Stigma

Stigma associated with both intimate partner violence and perinatal depression can often be a difficult challenge to overcome and often undermine efforts to combat IPV/PD. Women may feel judged if they admit to experiencing IPV or PD. Even providers and staff may have preconceived judgments or views about IPV/PD or may even be experiencing IPV/PD themselves, which make it difficult to work with consumers. Stigma encompasses that from: 1) society at large (social norms and societal stigmas) and 2) "self-stigma" where an individual adopts and internalizes the social stigma, leading to loss of self-esteem and self-efficacy.

Part of any raising awareness campaign's goals should be to reduce stigma in the community and among providers/staff. Research shows that providing individuals with factual information is the best way to decrease stigma (Penn & Couture, 2002). Think about how your message can help debunk the myths about IPV/PD, provide facts, make consumers feel that they are not alone, and advertise help available in your community. Use information and statistics from Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression (pg 8) to help construct your organization's message.

which allows you to focus your message into one succinct and specific message.

Create a simple, evidence-based definition of the problem. It should be easy to understand and accessible to anyone. Examples of definitions for IPV and PD include: IPV is defined as physical, sexual, or psychological harm between two people in a close relationship and may be used interchangeably with the term domestic violence. PD will include any depression occurring before pregnancy, during pregnancy, or up to 12 months after birth. Please refer to Section 1: Making the Case to Address Intimate Partner Violence and Perinatal Depression (pg 8) for more in-depth information and definitions.

Employ basic journalism questions to make the issues more accessible and easy to understand and interpret such as:

- What is the issue? -› How are IPV and PD related?
- Who does it affect? -› Who is affected by IPV/PD? Women? Families? Children? Society at large? What are the prevalence rates?
- Where is it happening? -› Do you have an estimate of prevalence in your community? Can you estimate based on the population and who is affected at a national level?
- When does it happen? -› At what point in a women's life is she most at risk? What are the signs?
- What can we do? -› Where can women be screened? What is the treatment and support systems in place for IPV/PD?

Developing effective solutions increases the legitimacy of your campaign. In the case of IPV and PD, you will want to discuss the importance of prevention, screening, treatment and referral. You will want to research and know what resources and help are available in your community already. You do not want to start a huge campaign asking women to be screened if you do not know what resources are available to them should they screen positive. You may need to set up partnerships and a referral system before you are able to employ a raising awareness campaign (please refer to Section 3: Partnerships (pg 40), for information on building a referral system).

- You can encourage local leaders and partners to employ these potential solutions. You may use your awareness campaign to develop partnerships and create a Referral Care Pathway in your community (please refer to Section 3: Partnerships (pg 40)).
- Part of your comprehensive information gathering should include previously attempted solutions and inclusion of why they were or were not effective.

A Person Who is Effective at Raising Awareness:

- Has a relevant story to tell
- Knows and understands the facts and data about IPV and PD
- Leverages expertise
- Networks with potential partners and relevant decision-makers
- Is persistent and goal-oriented
- Strives to be cooperative and positive

Distribute Your Message.

There are many avenues available to distribute your message. Below are some common strategies:

- Print Media. Conducting a writing campaign (e.g. articles or publishing advertisements). Once materials are printed it can be costly to reprint, so consider putting all materials online for easy, cost-effective access.
- Television and Radio. Work with you local television and radio media and ask to be interviewed about IPV/PD and services available. Utilize "awareness" months or relevant news stories that have occurred to highlight your work.
  - National Domestic Violence Awareness month is October. Many organizations support this effort including The National Coalition Against Domestic Violence, The White House, and many state/local governments and agencies.
  - Maternal Depression Awareness month is May. Many organizations support this effort including Postpartum Support International and many state/local governments and agencies.
- Events. Hold trainings, fundraisers, and community events to spread your message.

CAMPAIGN HIGHLIGHT

State: New Jersey
Project Name: The New Jersey Perinatal Depression Awareness Campaign
Website: http://www.njspeakup.gov

The New Jersey campaign entitled "Recognizing Postpartum Depression: Speak Up When You're Down offers a multitude of resources on their website to address perinatal depression. The 1-800 hotline is prominently displayed as well as video vignettes of women's stories regarding their experiences with perinatal depression. There is a separate section for health care professionals, friends and family as well as news and information. The section for health professionals offers a video to view answering the most common questions asked by providers regarding perinatal depression. There are also patient resources available to download for free on the website. The section for family and friends contains "Family Stories" where friends and family share their experiences in trying to get help for their loved one with perinatal depression. The news and information section contains press releases, a press kit and news coverage. The NJ campaign has been adopted by other states including California and Washington, and highlights the idea that we do not need to "re-create the wheel" in order to have a successful campaign.

The Washington State Postpartum Depression Awareness Campaign, "Speak Up When You're Down," encourages women and their families to talk opening with each other and with their healthcare provider when they are feeling depressed. The campaign also provides a statewide, toll-free line operated by Postpartum Support International of Washington.

Website: http://www.del.wa.gov/development/strengthening/speakup.aspx

The Los Angeles County Perinatal Mental Health Task Force site also provides example brochures (in Spanish and English) and information about perinatal depression.

Website: http://www.jlla.org/?nd=speakup

Exercise 1. Creating an Elevator Pitch.

An "elevator pitch" is a 30-60 second introduction of yourself, your business, or in this instance, your awareness campaign.

Pretend for a moment that your campaign is about to kick off: you have identified goals and tactics for your awareness campaign and you know what success looks like. By chance, you step onto an elevator with head administrator of your local hospital, who you've identified as a target for your campaign because he/she would be a powerful ally for implementing IPV/PD screening. You have 45 seconds to take advantage of your lucky encounter and introduce yourself and your awareness campaign – what do you say?

Part of your team's effort to craft a message should include creating a few elevator pitches to use in instances such as these, or when reaching out to media, networking at events, etc. Elements of a successful elevator speech include:

Succinct. Short, but inclusive of all key information

Attention – grabbing. Use strong language; tell a personal story, or shocking statistics. A good elevator pitch is like a popular song – it has a hook or line designed to draw your audience in and engage them.

On target. Use language that speaks to that particular audience.

Action-oriented. Use action words to describe exactly what that person can do, or what you hope to achieve. Similar to the goals you've identified for your campaign, include a feasible, realistic goal or action that you need. Use action verbs to stress how this person can be of help. "Attend X Meeting." "Call X person." "Donate X amount." "Watch X interview."

Tips for crafting the perfect elevator pitch:

- Brainstorm short stories, personal anecdotes, or statistics that are attention-grabbing.
- Identify the who, what, when, and where. Create the short version of what it is you're doing and what you need.
- Write it down.
- Practice. Record yourself, or practice your pitch with other team members.

EXAMPLE: "Hi, my name is Jane and I work with the Healthy Start program here in our community. I think you might be interested to know that many women in our community are experiencing both intimate partner violence and perinatal depression, and the effects on women and their children are staggering. Not only do pregnant women experience stress which could exacerbate depression, but research shows that pregnant women have a 35 percent greater chance of experiencing intimate partner violence than non-pregnant woman. We have started a campaign to raise awareness about the intersection of intimate partner violence and perinatal depression, and are encouraging women to be screened and seek help. There is an event next Saturday. I hope you can attend so you can learn more about the great work we do. I'll drop off some additional materials at your office and then follow-up tomorrow with your secretary to see if you have any questions about when and where to show up."

- Social Media. Connect with partners and other interesting organizations through social media, and consider producing initial social media connections. You can reach a large number of people, and avoid recreating social media initiatives currently in place in your community. Social media includes websites, Twitter, Facebook, online petitions, and blogging. This type of media is able to reach a large number of people fast because the message often spreads quickly. Learning to use social media can greatly increase the reach of your message.

Using Social Media and Websites

The use of social media may either seem very intimidating or overly simple. This is why it is important to have a basic understanding of how, when, and why to use social media. The Internet and online raising awareness campaigns can be incredibly useful to inform the pubic, mobilize people, and organize. Most online tools already exist (at low or no cost) and are available for you to employ when raising awareness.

It may feel as though there is so much happening in social media, that you will be unable to get your message out in a relevant and memorable manner. However, when you treat social media not as a time waster, but as a legitimate aspect of your communication strategy, it becomes less overwhelming. Highlighted below are the most common forms of social media. They are by no means the only forms, for example YouTube, Flicker, etc are all viable means of social communication, and if you or your organization has experience working within those you should employ them as well.

CAMPAIGN HIGHLIGHT

Resources for You to Customize and Use Campaign: The National Resource Center on Domestic Violence, Domestic Violence Awareness Project Website: http://www.nrcdv.org/dvam/

The National Resource Center on Domestic Violence provides a plethora of materials on domestic violence. As part of their effort, the DV Awareness Project houses The 2011 Campaign in a Box. This includes "a collection of sample materials that can be customized for individual use, educational webinars, and other useful tools to enhance your prevention and awareness efforts. All materials were developed in conjunction with the various organizations represented on the Project Advisory Group, as well as other national, statewide, and culturally specific organizations, projects, and individuals."

Also see the "Clothesline Project" Website: http://www.clotheslineproject.org/index.htm

This project, as part of the Domestic Violence Awareness Project, uses t-shirts to bear witness to violence against women and children.

WEBSITE HIGHLIGHT

State: Ohio
Program: Cleveland Regional Perinatal Network
Website: http://www.crpn.net

The Cleveland Regional Perinatal Network created a website dedicated to perinatal depression. Included on this website is information for both consumers and providers. There are also excellent examples of brochures, posters, a television commercial, and screening and referral materials. For more information about the Cuyahoga County Healthy Start and Cleveland Regional Perinatal Network, please refer to Section 3: Partnerships (pg 40).

Website

More than likely your organization already has a website. Make sure your website has information about IPV and PD woven throughout the website—as it would be in a comprehensive health care approach. This page should have links to your other social media sites, should be maintained and updated frequently, and should be user-friendly with photos and an appealing visual layout. The more you update and post on your website, the more internet traffic you will have. It will also establish your organization as one that is "in the know" and identify your site as one that people rely on for information.

Email

Information can be quickly shared through emails. Distribution of an electronic newsletter is a fast and effective way to share information. Remember that people hate spam. When creating an email newsletter or e-blast keep it concise with new information. Use these as an opportunity to direct subscribers to other sites such as your blog, website, or Facebook page for more information. Allow subscribers on your listserv to choose how often they receive updates (i.e. once a day, weekly or monthly digests).

Blogs

Blogs are an easy way to keep your audience updated on the issues and keep them coming back for more new content. They are typically written in more approachable language, often highlighting personal experience. For this reason, an IPV/PD blog could be particularly appealing to your target population as a place to receive information and learn about others' experience. Oftentimes blogs are best at humanizing and personalizing the issues. It should be noted that blogs are one person's experience and there is generally no one that monitors the information (unless it is associated with an organization), so the information may not be accurate. If your organization chooses to host a blog with such experiences, be sure that information is accurate to maintain credibility of the organization.

Social Media

Social Media sites are now a major source for information. Many of these sites allow people to share and spread information quickly and in a concise format, such as Tumblr, Twitter, Facebook, and many others. Once a network of followers is built, it can easily spread messages and reminders about your IPV/PD initiative. For example you could send reminders about screening, referral and treatment options for IPV/PD, recommend partner organizations for women to visit, or advertise an event you are hosting. Often social media is cost-effective and is an effective way to humanize your message and reach your target population in places where they already are. Remember, if your campaign is going to have social media accounts then you have to participate regularly. Don't start a feed only to never update it or you will quickly lose supporters/followers.

Hosting Events

There are many different types of events that your organization may hold as part of your awareness campaign. It may be as small as a meeting between you and your partners, a training for staff/partners or community members, or a large fundraising event, to name just a few. Regardless of the type of event held, there are a few important tips for creating a successful event.

- Envision your event. Similar to the questions answered in Step 1 for creating your awareness campaign, determine the goal of your event. Define what success will look like.
- Determine the resources you have to work with. Who will take leadership roles in organizing the event, leading the event, and providing support? What types of material/content will you need to utilize, find, or create? What resources will you need in terms of equipment, space, funds, etc?
- Organize Logistics. After you have determined the type of event that you would like to host, consider the following questions.
  - How many people do we expect to attend?
  - What facility or space is best suited to our needs?
  - Who should we invite? Make sure to provide clear details to invitees.

  - What type of room setup would best facilitate the event? For example, will there be a section for refreshments and food? Will attendees need tables to write notes or eat at, or will they only be listening to a presentation? Is the facility compliant with disability requirements?
  - What types of audio visual equipment will you need - Will you need a projector and screen? Will you need microphones? Will the event be recorded (audio and visual)?

Make sure to advertise your events, meetings, trainings, etc. through resources that have already been developed. For example, post on a calendar or upcoming events section of your website; post on social media outlets, reach out to the media to advertise for you; and ask partners or supporters to do the same through all means available to them.

  - Do you need materials such as name tags, notebooks, brochures on your organization, etc.

- Advertise. Get the word out – leverage partnerships, media contacts, and social media to advertise your event and target the type of attendees you want to attend.
- Follow up. Conduct a debriefing session with team members after the event to determine if you met your goals, ways of improving in the future, and dealing with any follow-up/next steps such as thanking attendees or paying invoices.

Other tips and ideas include hosting an event online through webinars or over the phone, and making sure to have resources about your organization or campaign such as brochures, wallet cards, or business cards that your team members can pass out to attendees.

Raising awareness may be beneficial to your organization by educating community members, attracting new partners, and encouraging utilization of the services your organization provides. The steps involved in a successful raising awareness campaign include getting informed about IPV and PD through research, developing a strategic plan by establishing specific goals and a target audience, and implementing the plan by distributing your message. The following tools and resources provide detailed tips and examples of how to successfully conduct a raising awareness campaign.

TOOLS AND RESOURCES

Association of Maternal and Child Health Programs

Website: http://www.amchp.org

As part of the valuable resources available on this site, there is information and tools related to raising awareness. There is a section to help you with writing a blog piece with examples of recent editorials related to maternal and child health.

Early Childhood Learning & Knowledge Center (ECLKC)

Website: http://www.eclkc.ohs.acf.hhs.gov/hslc

The ECLKC offers a Head Start Center locator that can assist communities in developing partnerships along with myriad resources related to parent engagement, health, mental health, and early care and education of young children that is useful to parents, educators, and other professionals working with low income families.

Futures without Violence

Website: http://www.futureswithoutviolence.org

As part of their effort to advance the health, stability, education and security of women and girls, men and boys worldwide, Futures without Violence strives to change social norms. By training professionals including doctors, nurses, athletic coaches, and judges, they improve responses to violence and abuse. They also work with advocates and policymakers to educate people about the importance of respect and healthy relationships.

MedEdPPD

Website: http://www.mededppd.org/mothers

MedEdPPD, developed with support from the National Institutes of Health has a special section just for moms. Watch videos or read information about postpartum depression (PPD), search for a provider, take the Edinburgh Postnatal Depression Scale (EDPS), access brochures, and much more.

Mental Health America

Website: http://www.nmha.org

Mental Health America provides information about postpartum depression and how to find local providers and support groups.

National Head Start Association

Website: http://www.nhsa.org

This site provides information and ideas related to NHSA's advocacy efforts including contacting policymakers and working with business leaders.

National Center on Domestic Violence, Trauma, and Mental Health

Website: http://www.nationalcenterdvtraumamh.org

This site provides detailing information on the traumatic impacts of intimate partner violence and how to offer a trauma-informed response to those who have experienced intimate partner violence.

Postpartum Support International

Website: http://www.postpartum.net

Postpartum Support International provides resources and information about perinatal depression to educate family, friends, moms and health care providers about postpartum depression. Resources available include an educational DVD, brochures, guidebook for support networks, resources for fathers, conference recordings, awareness posters, t-shirts and additional resources.

Resources for Dads:

Postpartum Dads

Website: http://postpartumdads.org

"PostpartumDads is a web site intended to help dads and families by providing firsthand information and guidance through the experience of postpartum depression" (PostpartumMen, n.d.).

Postpartum Men

Website: http://www.postpartummen.com

"PostpartumMen is a place for men with concerns about depression, anxiety or other problems with mood after the birth of a child. It promotes self-help, provides important information for fathers – including a self-assessment for postpartum depression – hosts an online forum for dads to talk to each other, offers resources, gathers new information about men's experiences postpartum, and – most importantly – helps fathers to beat the baby blues" (PostpartumMen, n.d.).

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

Tool 1. Plan of Action for Raising Awareness

Example of a Resource Checklist

Resource	Citation	Key Points
Futures Without Violence Website	Website: http://futureswithoutviolence.org	– Statistics on prevalence of IPV and PD – Helpful PowerPoint that can be used in trainings for IPV and PD – Campaign materials and tools that can be printed and used – Staff Member that may be able to conduct training for staff, knows other activists we could talk to.
National Online Resource Center for Violence Against Women	Website: http://vawnet.org	– Good website to list on our organization's website – Links to materials and teaching resources that can be printed to educate staff – A monthly e-newsletter filled with stories of actions other organizations are successfully taking

Tool 1. Plan of Action for Raising Awareness, Continued

Examples of Identifying and Measuring Goals

Goal	Measure	Team Member Responsible	Date to Be Completed
Conduct training events in the community on IPD/PD	Conduct 3 training events, each with 10 participants.	One staff member in charge of the goal in its entirety Or, one staff member in charge of each training	Within 12 months
Conduct training events in the community on IPD/PD	Conduct 6 trainings, each with 10 participants, for under $100 per each training.	One staff member is in charge of creating content for the trainings free of charge (3 trainings) One staff member is in charge of outreach and advertising the event with $25 (10 participants) One staff member is in charge of logistics - finding a space for the training, scheduling a trainer, getting a local restaurant to sponsor refreshments, within a budget of $75	One training every other month for the next year
Reach out to local media	Publish 1 letter to the editor within a local newspaper Conduct a publicized interview with a local radio station or tv news channel	Have 1 staff member in charge of writing all material - the letter, talking points for the interview, and language for the ad Have another staff member responsible for calling local media outlets to schedule an interview and posting the ad online Have a volunteer responsible for sending the letter to the editor	Every 3 months
Reach out to local media	Publish 1 letter to the editor within a local newspaper Place 2 ads online for an upcoming IPV/PD training	Have one staff member in charge of writing letters to the editor of 4 local newspapers every week to try to have one published Set another staff member in charge of identifying places to post the online ad and actually posting online	Every 3 months
Reach out to local media	Find a local print shop to provide 15 free posters that can be posted in 3 community health centers in your town	A committee of 3 outreach team members create a poster design At your next staff meeting, hang the posters in the community health centers together	Have a poster design ready in two weeks Contact the print shop in one month Hang posters in 2 months

NOTES PAGE

NOTES PAGE

Section 5

CULTURAL AND LINGUISTIC COMPETENCY

STRATEGIC OVERVIEW

This section of the toolkit can be used to begin working with the concepts of cultural and linguistic competence within your organization. In this section you will find definitions of cultural and linguistic competence, resources for assessing an organization's competency level, tips for developing a workplan, and quality resources for training all members of an organization.

Considering a person's background and culture is essential when working with the issues of intimate partner violence (IPV) and perinatal depression (PD). Cultural and linguistic competence should be considered in order to be respectful of a person's experiences and to provide quality services.

The term "cultural competence" was defined by Terry L. Cross in 1989 as a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals, which enable individuals to work effectively in cross-cultural situations (Cross, Bazron, Dennis & Isaacs, 1989).

Goals of this Section:

1. Describe what cultural and linguistic competency is and why it is important for addressing intimate partner violence (IPV) and perinatal depression (PD)
2. Explain how to examine cultural and linguistic competency in an organization
3. Provide tools for staff development related to cultural and linguistic competency

"Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency" (Betancourt, Green, & Carrillo, 2002). Cross et al. (1989) define cultural competence as, "a set of behaviors, attitudes, and policies that come together in a system, agency, or among professionals, which enable individuals to work effectively in cross-cultural situations." Cross' definition is widely accepted in the United States and is employed throughout many government agencies, such as the Office of Minority Health (HHS, 2012) and the Centers for Disease Control and Prevention's National Prevention Information Network (CDC, 2012).

In order to provide appropriate, quality care for all clients, creating a cultural and linguistic competency action plan for your organization can lead to

increased benefits for all clients. Many believe culturally competent care may eliminate or reduce racial/ethnic health disparities by increasing access to quality care for patients (Betancourt et al., 2002). It is important that providers understand the "impact of social and cultural factors on health beliefs and behaviors" (Betancourt et al., 2002).

What effect do social and cultural factors have on individuals' health experiences, and what does cultural and linguistic competence look like in practice? As individuals we define culture based on our own unique set of experiences and beliefs. Culture may also be defined as, " ...the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding that are learned through a process of socialization. These shared patterns identify the members of a culture group while also distinguishing those of another group" (University of Minnesota, Center for Advanced Research on Language Acquisition, n.d.). The Office of Behavioral and Social Sciences Research explains the effect of social cultural factors, "Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviors, the effectiveness of health promotion efforts, and access to, availability of, and quality of health care. Social and cultural factors also play a role in shaping perceptions of and responses to health problems and the impact of poor health on individuals' lives and well-being" (HHS, n.d.).

Researchers agree that client's varying cultural and linguistic needs may create barriers to accessing timely, appropriate, equal, quality health care (HHS, n.d.). An organization's goal is therefore to remove these barriers as much as possible, in order to help clients dealing with IPV/PD. In addition, cultural and linguistic competence may increase one's health literacy, or the ability of client's to obtain, process and understand health information and make appropriate health decisions.

A culturally and linguistically competent system ensures involvement from individuals and organizations at all levels (Goode & Sockalingam, 2000). Cultural competence requires organizational change and a commitment or willingness on the part of everyone within the system to undergo a transformation. It requires staff to not only reflect and re-evaluate health values, beliefs, practices, and behaviors, but to also acknowledge and address social determinants such as oppression, suppression, bias, and institutional prejudices (Goode & Sockalingam, 2000). Each component of an organization, including front line staff, supervisors, cleaning staff, and reception staff, are needed if an organization is to take a holistic, inclusive approach to integrating cultural and linguistic competency (Goode & Sockalingam, 2000).

Organizations that provide culturally competent services are striving to meet the needs of their community. In order to provide high quality services, an organization should recognize and accept the diversity and traditions of different cultures. Tailoring the participant visit to their experiences, traditions, and customs is integral. Working towards cultural competence can also be an interesting and enriching experience for everyone involved.

Building culturally competent organizations means changing how people think about other cultures, how they communicate, and how they operate. It means that the structure, leadership, and activities of an organization must reflect many values, perspectives, styles, and priorities. A culturally competent organization emphasizes the advantages of cultural diversity, celebrates the contributions of each culture, encourages the positive outcomes of interacting with many cultures, and supports the sharing of power among people from different cultures. To really change, an organization has to commit to the creation of an organizational climate that is inclusive of all cultures and celebrates diversity as well as organizational policies and procedures that supports inclusive, appropriate and high quality service provision.

The National Center for Cultural Competence which is funded through a cooperative agreement between the Health Resources and Services Administration and Georgetown University assists organizations with transitioning the theory of cultural and linguistic competency into practice. The National Center for Cultural Competence states that cultural competence requires organizations to work towards the following goals: 1) Developing values and principles which enable organizations to work effectively and cross-culturally by demonstrating behaviors, attitudes, policies and structures that are culturally and linguistically appropriate for the community served. 2) Organizations should have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve.

The Children and Youth with Special Health Care Needs, the SIDS/SUID and the Division of MCH Workforce Development Projects of the National Center for Cultural Competence are funded by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration, U.S. Department of Health and Human Services (grant number U40MC00145-17-00). For more information about the National Center for Cultural Competence go to http://nccc.georgetown.edu.

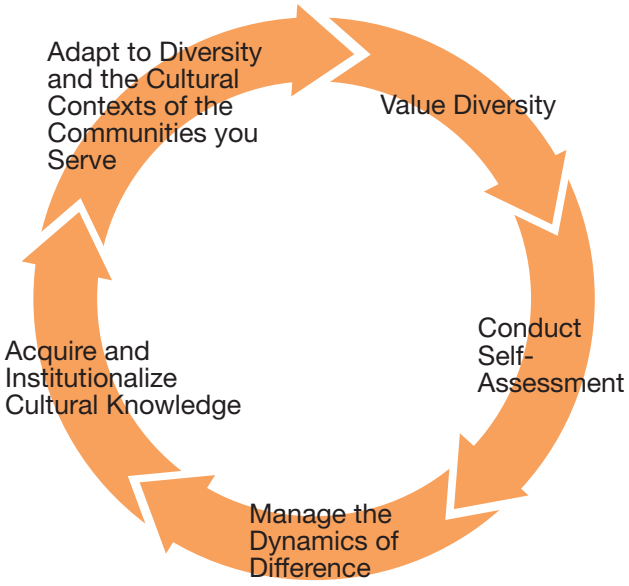


Figure 1. Goals for Enhancing an Organization's Cultural Competence Capacity

More specifically, the Office of Minority Health outlines 15 National Standards on Culturally and Linguistically Appropriate Services (CLAS). These include hiring diverse staff, conducting self assessments, providing continuous staff training.

PROGRAM HIGHLIGHT

State: Iowa
Program: Des Moines Healthy Start, Visiting Nurse Services of Iowa
Website: http://www.vnsdm.org

Addressing Cultural and Language Barriers with Refugee Communities

The Des Moines Healthy Start program has mindfully addressed the needs of refugee communities and is meeting their community's most basic and important needs. The administrators of the Healthy Start program recognized the need to respond to the changing demographics and worked to meet the needs of the changing community. The Healthy Start program was able to hire bi-lingual and bi-cultural outreach workers and case managers by partnering with local leaders from the refugee communities. To date outreach workers speak a total of 21 languages (Arabic, Bendi, Bosnian, Burmese, Chin Lai, Chin Mizo, Hindi, Kachin, Karen, Karenni, Laotian, Nepali, Nuba, Russian, Shan, Somali, Spanish, Swahili, Thai, Thai Dom, Vietnamese) and case managers speak 4 languages (Spanish, Arabic, Nuer, French).

Examining cultural competence in your organization

To increase your organization's capacity for cultural and linguistic competence you must first value diversity and conduct a self assessment. Complete Tool 1. Cultural Considerations in Your Community (pg 87) to begin the process of assessing your organizations approach to culture.

There are many different and valuable tools available online that can assist an organization in developing a work plan and working towards cultural competency. These tools allow organizations and staff to examine and evaluate their core beliefs, policies, and practices.

Examining your organizations and staff core beliefs, policies and practices

It is very important to ensure that all parts of an organization are participating in a cultural competence initiative. Mandates from an organization's administration are rarely effective. But initiatives that involve staff from all organizational levels are most successful. For example if your organization chooses to establish a cultural competence committee it is important to have representations from upper management to reception and front line staff (KU Workgroup for Community Health and Development, 2010).

Additional tools to help your organization assess cultural competence include:

- The Cultural and Linguistic Competence Policy Assessment (CLCPA) developed by the National Center for Cultural Competency.

  Website: http://www.clcpa.info/

- The Provider's Guide to Quality & Culture, Evaluating Oneself.

  Website: http://erc.msh.org/mainpage.cfm?file=2.2.htm&module=provider&language=English

- The Cultural Competency Organizational Self Assessment (OSA) Question Bank

  Website: http://www.aidsetc.org/aidsetc?page=etres-display&resource=etres-197&

After utilizing a self assessment tool, consider the following items when managing the dynamic of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and the cultural contexts of the community you serve.

- ✓ Develop a compassionate approach towards differences and change. Will the culture of your organization and its natural leaders willingly accept change?
- ✓ Develop partnerships with the cultural groups in your community. Please refer to Section 3: Partnerships (pg 40).
- ✓ Learn and address any barriers to creating change within your organization.
- ✓ Identify what resources your organization needs to change. Where in your community can you find assistance?
- ✓ Create an action plan with detailed goals, objectives and evaluation plan for how your organization will succeed.
- ✓ Assess the organization's existing level of cultural competence- where are the strengths and the need for improvement?
- ✓ Reflect periodically on the goals and objectives the organization has fulfilled and strategize for how to meet goals and objectives that prove to be challenging.

Tool 1. Cultural Considerations in Your Community

The Cultural Considerations Tool will help your organization to reflect on how your organization and staff addresses the needs of and interacts with participants from diverse cultures. The tool can be completed by individuals or by a group, and can be used to begin a conversation about how the staff, as a whole, can better serve their participants. It is important to note that the results of the Cultural Considerations Tool should be handled with care so that staff do not see it as an evaluation of their cultural competence, but instead as an opportunity to improve services.

Goals for staff:

- All staff understand the importance of cultural competency.
- An agency-wide process helps staff to understand how cultural and linguistic differences impact behaviors, and help staff achieve and maintain cultural competency.
- Staff represent and/or appreciate diverse racial, ethnic, and cultural backgrounds.
- Staff understand how to utilize language interpreters.

It may also be worthwhile to consider bringing in a person well versed in cultural competence to help staff effectively communicate. If you think there is a chance that someone might get offended an expert facilitator may be helpful. If hurt feelings, disagreements, or conflicts are unresolved when the meeting is over, staff members' interactions could be affected. Addressing cultural competence at an organizational and individual level is hard work, but well worth the effort.

1. What is your organization's vision for cultural competence? What is your community's vision for cultural competence?

   _____

   _____

   _____

2. Our leadership is supportive of working towards cultural competency.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   a. Describe your selection by indicating the level of support the organization's leadership will give in working towards cultural competence.

      _____

      _____

      _____

      _____

3. Our staff is supportive of working towards cultural competency.

Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

   a. Describe your selection by indicating the level of support the organization's staff will give in working towards cultural competence.

_____

_____

_____

_____

4. What are the primary cultural groups and languages represented in your community?

_____

_____

_____

5. What cultural groups are well (and poorly) represented by staff in your organization?

_____

_____

_____

_____

6. What languages are spoken by staff and do they represent those found in your community?

_____

_____

_____

7. How confident are you that staff accept and respect cultural differences and customs and beliefs?

Not Confident	Somewhat Confident	Confident	Very Confident
☐	☐	☐	☐

   If you are not confident, explain why and what may be needed to increase confidence.

_____

_____

_____

8. How confident are you that staff agree and accept that traditional beliefs may influence how families respond to depression, wellness, disease, violence and death?

Not Confident	Somewhat Confident	Confident	Very Confident
☐	☐	☐	☐

If you are not confident, explain why and what may be needed to increase confidence.

_____

_____

_____

9. Describe how people of different cultures interact with the organization and how the organization and staff interact with people of different cultures. *(For example, not at all, with respect)*.

_____

_____

_____

10. What special services or arrangements does the organization have for diverse participants?

_____

_____

_____

11. Describe the organization's process for assessing the need for a translator or "language line."

_____

_____

_____

12. If the organization uses interpreters, have staff received training on effectively using interpretation services and language lines? If yes, please describe:

☐ Yes ☐ No

_____

_____

_____

13. In the past three years, what types of training or events have staff been provided in the area of cultural competency?

Training Topics	How Provided (face-to-face, on-line, train-the-trainer)

_____

_____

_____

14. Describe any issues, policies, or procedures that are barriers to staff providing quality services for diverse participants.

_____

_____

_____

15. Are members of diverse cultural and social groups full participants in all facets of the organization's work (including planning, implementation, and evaluation/feedback)?

Never	Not Often	Sometimes	Always
☐	☐	☐	☐

_____

_____

_____

16. Describe the identified needs of the organization and possible steps to move toward cultural competence.

_____

_____

_____

17. Describe the organization's readiness to change its established systems and policies in order to move toward cultural competency.

_____

_____

_____

18. What is your goal for cultural competence at the:

Individual level:

_____

Organizational level:

_____

Program level:

_____

Community level:

_____

AFTER COMPLETING THE CULTURAL CONSIDERATIONS TOOL

Acquiring knowledge, adapting and institutionalizing cultural and linguistic competent values and practices is challenging. The Office of Minority Health outlines 15 National Standards on Culturally and Linguistically Appropriate Services, which may be helpful in creating an action plan. Website: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

Creating an appropriate action plan with goals for implementing culturally and linguistically competent practices may include a variety of items, such as:

- Hire culturally and linguistically diverse staff within your organization (Betancourt et al., 2002)
- Collect race/ethnicity and language preference data from clients (Betancourt et al., 2002)
- Hold staff development and training opportunities related to cultural and linguistic competency
- Discuss the policies and procedures of your organization as they relate to providing culturally and linguistically appropriate care
- Attend cultural events in your community
- Host cross-cultural events in your organization
- Discuss barriers to communication and practice or role-play communication skills
- Discuss strategies for dealing with racism and bias
- Share information about the multiple sociocultural factors that influence your clients' health and their experience of healthcare
- Create a language access plan for clients - establish preferred language at first point of contact, use written translations, make interpreter services available, utilize language hotlines, hire bilingual staff, and provide materials, services, and resources in your clients preferred language, taking into consideration literacy level.
- Identify and implement, "federal and state reimbursement strategies for interpreter services." (Betancourt et al., 2002)
- Consider, "Developing health information for patients that is written at the appropriate literacy level and is targeted to the language and cultural norms of specific populations." (Betancourt et al., 2002)

In all of these efforts, consider fostering partnerships with organizations and individuals in your community that not only represent the diverse community your organization serves, but may have successfully implemented cultural and linguistic competency plans in their own organization. For more information on creating partnerships, see Section 3: Partnerships (pg 40).

Resources for Cultural Competency

This section provides a list of resources that can be used to support or enhance an organization's ability to provide culturally and linguistically appropriate services. The resources outlined below provide examples of effective methods for professional staff development as well as more detailed information about cultural and linguistic competency. Some resources can be useful for your staff to complete, or they may offer ideas and information that can be used in developing a unique, personalized pathway to increasing an organization's cultural competency.

The Office of Minority Health offers several on line training curricula for health care providers. Although targeting a specific level of health provider, the information largely applies to many persons providing services to the public.

Website: http://www.thinkculturalhealth.hhs.gov/content/ContinuingEd.asp

The Office of Minority Health also provides "National Standards for Culturally and Linguistically Appropriate Services in Health Care"

Website: http://www.minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf

The "Physician's Practical Guide to Culturally Competent Care" offers CME/CE credit and "equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve."

Website: http://cccm.thinkculturalhealth.hhs.gov

The "Cultural Competency Curriculum for Disaster Preparedness and Crisis Response" offers a free online course targeting social workers, disaster mental health workers, first responders (including EMTs and firefighters) and emergency managers.

Website: http://cccdpcr.thinkculturalhealth.hhs.gov

The National Center for Cultural Competence at Georgetown University offers several online resources including: "Cultural Competence- It all starts at the front desk."

Website: http://nccc.georgetown.edu/documents/FrontDeskArticle.pdf

"Planning, Implementing and Evaluating Culturally Competent Service Delivery Systems in Primary Health Care Settings", which targets policy makers and administrators beginning to addressing cultural competence.

Website: http://nccc.georgetown.edu/documents/Getting_Started.html

Health Resources and Services Administration provides a video and several links to help organizations gain a better understanding of culture, language, and health literacy and how that affects clients' experiences of health care.

Website: http://www.hrsa.gov/culturalcompetence/index.html

The Community Toolbox (2012) from the University of Kansas (KU) Workgroup for Community Health and Development offers tips on Cultural Competency.

Website: http://ctb.ku.edu/en/dothework/tools_tk_9.aspx

The Asian & Pacific Islander Institute on Domestic Violence offers curricula and tools for cultural competency as well as a directory of programs serving Asian, Native Hawaiians, Pacific Islanders and Muslims, and translated materials for over 32 Asian and Pacific Islander languages and other interpretation resources.

Website: http://apiidv.org/

Casa de Esperanza's National Latin@ Network provides training on domestic violence and related critical issues for organizations serving Latinas and their families.

Website:
http://casadeesperanza.org/national-latino-network/

The Institute on Domestic Violence in the African American Community offers a webcast, "Cultural Competence, African Americans and Domestic Violence," which provides an overview of the cultural and societal influences that contribute to disparities as well as the implications for police and practice.

Website: http://dvinstitute.org/

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

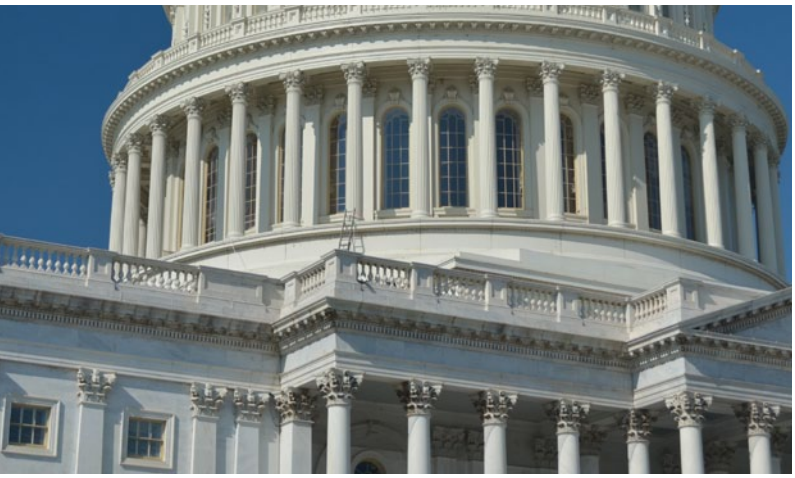
NOTES PAGE

Section 6



POLICY AND LEGISLATION

STRATEGIC OVERVIEW



Goal of this Section:

1. Provide examples of existing policy and legislation that address IPV/PD

Policy and legislation can play an important role in addressing intimate partner violence (IPV) and perinatal depression (PD). As a community-based organization, using raising awareness techniques can help you in advancing your message see Section 4: Raising Awareness (pg 62).

This section will highlight existing federal and state level efforts related to IPV and PD. Various state and federal policies may impact the way your community addresses these issues. This section lists examples of existing policy and legislation and resources for organizations to research the ways in which policy and legislation affect their community.

Federal Policy

A very brief overview of some of the successful federal legislation enacted previously to address IPV/PD is below.

Family Violence Prevention and Services Act of 1984:

The Family Violence Prevention and Services Act (FVPSA) provides the primary federal funding stream dedicated to the support of emergency shelter and related assistance for victims of domestic violence and their dependents. FVPSA is located in the Family and Youth Services Bureau (FYSB), a division of the Administration on Children, Youth and Families in the Administration for Children and Families. Through the FVPSA Program, FYSB administers FVPSA formula grants to states, territories, and tribes as well as to state domestic violence coalitions. In addition, it funds the National and Special-issue Resource Centers and the National Domestic Violence Hotline. For more information visit http://www.acf.hhs.gov/programs/fysb/content/programs/fv.htm

Victims of Crimes Act of 1984 (VOCA)

The Victims of Crime Act of (or VOCA as it is commonly known) 1984 establishes the Crime Victims Fund, a major funding source for victim services financed wholly through criminal fines, forfeited bail bonds penalties and special assessments. The Crime Victims Fund provides grants to states and territories for victim assistance and compensation, as well as program evaluation, training and technical assistance and related services. For more information visit http://www.ojp.usdoj.gov/ovc/pdftxt/VOCA_Chart_hr.pdf

Violence Against Women Act of 1994:

The Violence Against Women Act of 1994 (or VAWA as it is commonly known) and its subsequent reauthorizations establish domestic violence, sexual assault, dating violence and stalking as crimes, provide a legal assistance

program for victims and establish funding for survivor services and prevention programs. The Department of Justice's Office on Violence Against Women administers three formula-based and 18 discretionary grant programs under VAWA to help state, tribal and local governments and communities strengthen law enforcement and develop more effective responses to violence against women. The Department of Health and Human Services administers the National Domestic Violence Hotline and grants for women's shelters, rape prevention and education and community initiative programs. For more information visit http://www.ovw.usdoj.gov/overview.htm and http://assets.opencrs.com/rpts/RL30871_20100226.pdf

Affordable Care Act:

The Affordable Care Act is a federal statute signed by President Obama in March, 2010. Certain aspects of this legislation pertain to IPV and PD and are listed below.

As of September 2012, the Affordable Care Act requires health insurers, including Medicare, to offer certain preventive health services free of co-pays for new health plans.

- Depression screening, alcohol abuse screening/counseling, tobacco cessation, STI prevention screening/counseling for those at high risk

In July 2011, The Institute of Medicine Clinical Preventive Services for Women released recommendations for women and adolescent girls which included:

- Screening/counseling for interpersonal/domestic violence in a culturally sensitive and supportive manner

In August 2012, HHS Secretary Sebelius announced that insurance plans will make adjustments starting in January 2013. Complete insurance coverage without copays will include:

- IPV/DV, contraception methods, STI counseling, well woman visits

For more information visit http://healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforWomenIncludingPregnantWomen

State Policies

There are policies at the state level that have been successful in addressing IPV/PD. A comprehensive review of state policies was prepared in 2010 by the organization Futures Without Violence. The piece is titled: *Compendium of State Statutes and Policies on Domestic Violence and Health Care*. The report highlights the status of each state in its efforts concerning: fatality review, insurance discrimination, mandatory reporting, protocols for policies and procedures in providing services, screening policies and training policies. The full report can be found at Website: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf

Below are state-specific examples of success.

Massachusetts: Chapter 313, An Act Relative to postpartum depression. The law establishes a commission made up of legislators, state officials, healthcare providers, advocates and mothers who've experienced post-partum emotional stress, with the charge of strengthening PPD support programs in the state, including treatment, screening and public-awareness efforts. The focus is on earlier detection of postpartum mood disorders through screenings, improved collaborative efforts among health professionals for the treatment and referral of patients, the training healthcare providers, and public awareness campaigns.

California: Penal code 1163.3 and 1163.5. "A law that provides for county-level interagency domestic violence death review teams. These teams investigate both homicides and suicides related to domestic violence. The teams serve to ensure the role of domestic violence is recognized and that subsequent preventive measures are introduced. There is also coordination and integration of state and local efforts to learn from fatal domestic violence to prevent future domestic violence deaths (Violence Against Women Online Resources, n.d.)."

New Jersey: The law requires health care providers to screen women who recently have given birth for postpartum depression and teach women and their families about postpartum depression. The law, which provides $4.5 million in funding for education and screening, also requires providers to ask pregnant women about their history of depression or postpartum depression before they give birth (Murray & Cooper, 2006).

WHY STATE AND LOCAL POLICY IS IMPORTANT

There are several reasons why state and local policies have become increasingly critical to reduce intimate partner violence (IPV) and perinatal depression (PD). First, social policy is transferring from the Federal level to state and local governments. Second, the success of policy focused on IPV/PD depends on the effectiveness of local intermediaries and social networks, which can be influenced by state/local policy.

There are many state programs that are actively addressing IPV and PD, but few focusing on the intersection of IPV and PD. State Title V programs with highly developed IPV programs tend to have a high degree of synchronicity in terms of the methods used to address IPV. Mandated reporting of IPV, mandated screening of PD, awareness campaigns, home visiting, new parent programs, consortia or workgroups for perinatal health, and training for health care providers have been reported as highly effective strategies in several states. All of the strategies below have been enhanced by state policies and legislation.

Mandated reporting of IPV:

- In many states, social service providers are required by law to report to law enforcement physical injury as the result of an assault. California is one example (California Clinical Forensic Medical Training Center [CCFMTC], 2004).

Mandated screening of perinatal depression:

- Screening for postpartum depression (PPD) has been suggested as part of usual postpartum care by the American Congress of Obstetricians and Gynecologists (ACOG, 2010).
- Legislative mandates in the United States requiring postpartum depression screening began with New Jersey in 2006, continued with Illinois, and culminated in the introduction of Bill S 1375 the Mothers Act introduced to Congress in January 2009 (Murray & Cooper, 2006).
- Healthy Start programs are mandated to screen for perinatal depression (HHS, 2012).

Awareness campaigns (for additional resources please refer to Section 4: Raising Awareness (pg 62)):

- An awareness campaign provides knowledge and information to a large number of people about a specific issue.
- To bring an issue into the light an organized and systematic awareness campaign is valuable to promote discussion and provide resources.

PROGRAM HIGHLIGHT

State: Massachusetts
Program: The Massachusetts Department of Health and Human Services New Parent Program
Website: http://www.mass.gov/dph/newparents

The Massachusetts Department of Health and Human Services has created a program named the Massachusetts New Parent Initiative (MNPI). The initiative includes resources for families and providers. The provider section contains "digital stories" where there are videos showing the experiences of families and providers regarding parenthood. Also included is a provider discussion guide and brochures on the Care, Share, Bond initiative. The Parent section has tips, resources in your community, and real stories on how to Care for oneself, share experiences to learn from each other and bond with your baby.

Home visiting programs:

Home Visiting programs provide services by professionals within the home to parents, prenatally and/or with children. Services are often provided by nurses and social workers.

In Massachusetts the Home Visiting Program in the Department of Public Health is required to perform screening for IPV and PPD. The program screens approximately 600 people a year (Massachusetts Department of Health and Human Services, n.d.).

New parent programs:

New parent programs address the special social and health care needs of new parents. Massachusetts, highlighted below, has implemented a successful new parent initiative.

Consortia or workgroups for perinatal health:

A great deal can be accomplished when persons come together in support of a common cause. When consortia or workgroups are formed for IPV or PD their scope and effectiveness is magnified. Often workgroups are made up of representatives from many agencies such as Public Health, Criminal justice, and health insurers. Successful workgroups have also included survivors, physicians, and social workers. These workgroups share resources and expertise to inform the public about the work they do.

New Jersey, Indiana and Massachusetts are examples of states that have successful workgroups. In these states the workgroups help address PD on multitude of levels, which would be much more difficult to do otherwise. The amount of time it takes to form a workgroup and begin to see results will vary largely.

For more information, please refer to Section 3: Partnerships (pg 40) and Section 4: Raising Awareness (pg 62).

Training for health care providers:

Working effectively with persons with IPV/PD can be challenging for social service and healthcare providers. Effective training is needed in order to increase the ease of social service and healthcare providers so that they will be more apt to servicing women with IPV/PD.

Several states have created training programs for service providers. In New Jersey through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. Hospitals and private practitioners are receiving

assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period (Murray & Cooper, 2006).

A Perinatal Depression Resource: The Colorado Department of Public Health and the Environment

Website:
http://www.colorado.gov/cs/Satellite/CDPHE-PSD/CBON/1251618800600#postpartum

The Colorado Department of Public Health and the Environment has enacted a campaign on pregnancy related depression. There are three sections of the website: for women and their families, for professionals and training. The women and their families section allows women to take a screening tool for pregnancy related depression while on line. As well as many fact sheets and brochures available for download. The section for professionals contains information such as medication charts, recommended books, information on the Edinburgh perinatal depression screening tool and many other resources. The training link indicates that, at the time of writing this toolkit document, training resources will be coming soon.

Your organization can use the below policy brainstorming tool to begin a conversation regarding the policy needs in your community.

For information about your state, visit the Health Resources and Services Administration Maternal and Child Health Bureau website: http://www.mchb.hrsa.gov

Tool 1. Policy Brainstorming

Oftentimes people are unsure of where to start when it comes to considering new policies that would assist their work. This brainstorming tool will help your organization consider key issues and challenges, including stigmas and cultural barriers, and how policies could play a role in alleviating those challenges. Section 4: Raising Awareness (pg 62) provides tips for how you can begin the discussion in your community. As an organization you will need to decide who is best to complete this document or if it should be done as part of a team effort.

1. What are the key issues and challenges around IPV/PD in your community? *(Consider awareness of the issues, stigma, rates of IPV/PD, and resources available for screening, referral and treatment.)*

2. What are the stigmas around IPV/PD in your community?

3. What are the barriers around screening, referral, and treatment for IPV/PD in your community?

4. What are the cultural norms regarding IPV/PD in your community?

5. Are there policies that would help address the stigmas, barriers or cultural norms experienced in your community?

_____

_____

_____

_____

_____

6. Are there policies that would help your organization be able to screen, refer and treat women for IPV/PD?

_____

_____

_____

_____

_____

NOTES PAGE

Section 7

STANDARDS OF CARE GUIDELINES AND RECOMMENDATIONS FOR INTIMATE PARTNER VIOLENCE AND PERINATAL DEPRESSION

STRATEGIC OVERVIEW

Goals of this Section:

1. Provide examples of existing Standards of Care for intimate partner violence (IPV) and perinatal depression (PD)
2. Describe the process of implementing Standards of Care in your organization

There are several Standards of Care Guidelines for both intimate partner violence (IPV) and perinatal depression (PD), however few that address the intersection of these comorbidities. In this section are guidelines and more information including training materials, sample dialogues and screening questions, awareness materials and more. Please utilize this section as a resource catalog, though it is not meant to be exhaustive of all resources and guidelines available.

As mentioned in Section 4: Raising Awareness (pg 62), the majority of women do not mind being asked about IPV or PD, yet most of them are not asked about IPV or PD by providers. The majority of women (80 percent) are comfortable with the depression screening process (Buist et al., 2006) and 90 percent of women are comfortable with the IPV screening process (Zeitler et al., 2005). However, less than 50 percent of women are screened for perinatal depression (Seehusen et al., 2005), only 22 percent of providers use validated screening tools for perinatal depression (Seehusen et al., 2005), and only 10 percent of women report being screened for IPV by their OB/GYNs (Rodriguez et al., 1999). Therefore, it is important for organizations to be aware of the Standards of Care and validated screening tools available for both intimate partner violence and perinatal depression.

Standards of Care for Intimate Partner Violence (IPV)

Routine screening for IPV is endorsed by numerous health organizations (including ACOG, the Institute of Medicine, and the National Resource Center on Domestic Violence to name a few). Yet despite these recommendations, rates of screening in clinical practice remain low. Studies found that 1.5 percent to 12 percent of women in a primary care setting are ever asked by a physician about violence (Klap, Tang, Wells, Starks & Rodgriguez, 2007; Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000). And although reproductive health organizations have led the way on encouraging the use of screening devices, only 10 percent of obstetricians and gynecologists report using routine IPV screening in practice (Waalen et al., 2000). Still, screening tools exist for IPV and include the Woman Abuse Screening Tool (WAST), an 8-item instrument that measures physical, sexual, and emotional abuse in the last 12 months. Also, the Composite Abuse Scale, a 30-item instrument, measures overall exposure to violence. In addition, the Women's Experience with Battering Scale (WEB) asks 10 questions about how a woman feels, emotionally and physically. The WEB therefore collects information on physical and emotional abuse by measuring women's experiences and feelings instead of focusing on an intimate partner's behavior. These tools have been used in the clinical and

community health setting with success. A list of some of the validated screening tools is found in Table 1. Screening Tools for IPV and PD (pg 118).

In addition, research has shown that brochure-based interventions are effective and providers find that a brief intervention that uses a safety card and includes a referral to a local domestic violence or advocacy support agency is simple and effective.

Recommendations for Screening (ACOG, 2012):

- ✓ Screen all women for IPV at periodic intervals (including during obstetric care), offer ongoing support, and review available prevention and referral options.
- ✓ Screening for IPV during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup.
- ✓ Screen for IPV in a private and safe setting with the woman alone and not with her partner, friends, family, or caregiver.
- ✓ Use a strategy that does not convey judgment and one with which the woman feels comfortable.

PROVIDER TIP!

Prompts to Assess for IPV: watch for signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the patient does not wish to be pregnant, new or recurrent STIs, asking to be tested for an STI, or expressing fear when negotiating condom use with a partner (ACOG, 2012).

- ✓ Use professional language interpreters and not someone associated with the patient.
- ✓ At the beginning of the assessment, offer a framing statement to show that screening is done universally and not because IPV is suspected. Also, inform patients of the confidentiality of the discussion and exactly what state law mandates that a physician must disclose.
- ✓ Incorporate screening for IPV into the routine medical history by integrating questions into intake forms so that all patients are screened whether or not abuse is suspected.

It is important to discuss the limits of confidentiality before doing the screening. Again, scripts have been written on how to disclose limits of confidentiality with a patient before screening, and can be accessed through the resources listed at the end of this section. Mandatory reporting requirements are different in each state and territory. Consider contacting the following entities for information and resources specific to your state/region:

- ✓ Compendium of State Statutes and Policies on Domestic Violence and Health Care is an at-a-glance summary of state laws and regulations relevant to addressing domestic violence in health care settings: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf
- ✓ The domestic violence coalition in your state, which may have legal advocates or other experts that provide information and training on reporting requirements. For a complete list, go to http://www.nnedv.org/resources/coalitions.html
- ✓ If you need to make a report, there are several ways you can be supportive to your patient, including knowing your state law, informing your patient of your requirement to report, explaining what is likely to happen when the report is made, asking your patient if she is willing to call an advocate to develop a safety plan in case of retaliation, and making the report with the patient.
- ✓ In addition, it is important to keep in mind that women may not disclose experiences of IPV the first few times, if ever. In addition, clients may refuse services when offered.

PROGRAM HIGHLIGHT

State: Cleveland, Ohio
Program: MomsFirst, Cuyahoga County Healthy Start
Website: http://healthystart.cuyahogacounty.us/

Developing a Referral of Care Network to Address Gaps in Screening, Referral and Treatment

The MomsFirst Healthy Start program in the mid-west has been extremely successful in developing a Referral Care Pathway in order to streamline the referral process with partnering organizations across the County. The program set up an on-going Task Force to identify and fill gaps in screening, referral, and treatment for perinatal depression and secured providers and stakeholders within the community to commit to this effort. Initially the Task Force met monthly, but reduced their meetings to quarterly now that they are more established. The meetings help partners stay updated, connected, provide feedback and keep people committed to the effort. Partners are held accountable if they are part of this network. The Task Force developed and agreed upon a fax referral form which helps ensure a County-wide policy and procedure, that partnering agencies are all on the same page and are held accountable, and that women do not slip through the cracks. The program reduced the wait time for a woman who screened positive for perinatal depression from 2 months to less than 2 weeks, and ensured that the woman is contacted and spoken to within 72 hours of a positive screen. The program was careful to involve both public and private providers and organizations to reduce the burden of services. The Task Force has helped to expand the model to several surrounding Counties and often invite people from across the region to their meetings. Please refer to Tool 1. Example of a Referral Care Pathway Model (pg 119) for the Example Referral Care Pathway developed by the Cleveland Regional Perinatal Network. Website: http://www.crpn.net.

PROGRAM HIGHLIGHT

State: Arizona
Program: South Phoenix Healthy Start
Website: http://www.maricopa.gov/PublicHealth/programs/HealthyStart/

The South Phoenix Healthy Start integrates the Edinburgh Postnatal Depression Scale (EPDS) for all pregnant or postpartum participants and the Modified Abuse Screen (MAS) to screen for perinatal mood disorders and intimate partner violence for all female participants. Both tools are supervised by a nurse or social worker and all affirmative screenings result in a document referral and follow up plan.

The South Phoenix Healthy Start has also implemented various Standards of Care guidelines based on their program's needs to ensure that: providers connect face to face with clients, barriers to follow up care are documented, and in person support is provided for first group visits. The South Phoenix Healthy Start has created an integrated support network that assists clients in moving from the screening and referral process to the actual provision of much needed services. It is a community-based effort that involves multiple partners. Highlights from the programs' successful efforts to ensure a continuum of care include dedicated follow up procedures and crisis intervention, documented referral and follow up plans, staff ability to physically support clients as they are introduced to support group meetings and supervision by nurses or social workers.

Resource Catalog for Intimate Partner Violence

American Congress of Obstetricians and Gynecologists (ACOG) Committee Opinion on Intimate Partner Violence. (February 2012).

Website: http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co453.pdf?dmc=1&ts=20120305T0433158796

This publication includes input from ACOG experts, Futures without Violence, and the Center for Research on Women with Disabilities. The concise document gives background on intimate partner violence, including special populations such as adolescents, immigrant women, older women, and women with disabilities. It also discusses the role of the health provider and the importance of written protocols for routine assessment. An easy to follow table gives sample screening questions, information on how to frame the conversation, and dialogue to use when discussing confidentiality or introducing the screening questions.

Centers for Disease Control and Prevention Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings.

Website: http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf

This publication provides a larger resource catalog of assessment tools for intimate partner violence, including a description and copy of each tool, as well as information regarding validity and published studies using each tool.

Futures without Violence

Website: http://www.futureswithoutviolence.org

Futures without Violence also provides educational materials, IPV assessment and safety assessment tools (including scripts for IPV clinical assessment and reproductive coercion) and free technical assistance specifically for health care providers and health settings.

Included in this section of the website is information about Healthy Moms, Happy Babies; a train the trainers curriculum on domestic violence, reproductive coercion and children exposed. This curriculum was created to support states and their home visitation programs in developing a core competency strategy, ensuring that all home visitation programs are equipped to help women and children living in homes with domestic violence.

Website: http://www.futureswithoutviolence.org/content/features/detail/1459

Futures without Violence. National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings (February 2004).

Website: http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf

This comprehensive document endorses a set of national guidelines on screening for intimate partner violence including whom to screen, how often, and in what settings. This resource also includes materials that can be ordered and purchased including provider reference cards, safety cards, awareness materials, posters, videos, patient education, and trainer manuals and toolkits.

State Codes on Intimate Partner Violence Victimization Reporting Requirement for Healthcare Providers

Website: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf

Most states do not mandate reporting of IPV, do so only in certain circumstances (Futures without Violence, 2007), so it is important to know the laws in your state. It is important to contact and partner with local law enforcement and your local domestic violence agencies to become familiar with the laws in your jurisdiction. The above document provides an easy-to-use chart for the reporting requirements related to violence by state.

For more information on State Policies please see the Futures without Violence, Compendium of State Statues and Policies on Domestic Violence and Health Care.

National Institute of Justice - Intimate Partner Violence

Website: http://www.nij.gov/topics/crime/intimate-partner-violence/

This resource provides comprehensive background on the issue of intimate partner violence. Topics include a definition of intimate partner violence, discussion of the types of IPV, the causes and consequences, information on prevalence, intervention strategies as well as a discussion of how intimate partner violence is measured. The National Institute of Justice resource also provides information on specific considerations including the relationship between intimate partner violence and economic factors, domestic violence shelters, murder suicide, intimate partner stalking, and teen dating violence. Links to publications on intimate partner violence are also included, as well as a 2009 report entitled Practical Implications of Current Domestic Violence Research: For Law Enforcement, Prosecutors and Judges.

National Resource Center on Domestic Violence

Website: http://www.nrcdv.org

The National Resource Center on Domestic Violence (NRCDV) provides resources, published materials, grants and funding, and technical assistance and training. The National Resource Center on Domestic Violence also offers the following suggestion for providers: Consider the following steps: ask, affirm, offer harm reduction strategies, document, and refer when screening for IPV.

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

Standards of Care for Perinatal Depression (PD)

In spite of the high prevalence rates of postpartum depression, little attention has been paid to detecting and treating depression. One study of OB/GYN patients reported that 20 percent of patients met criteria for a psychiatric diagnosis of postpartum depression, yet the condition went unrecognized by the health care provider among 77 percent of the patients (Spitzer, Williams, Kroenke, Hornyak & McMurray, 2000). Furthermore, only 32 percent of OB/GYN physicians surveyed in another study felt they had been adequately trained to treat depression (LaRocco-Cockburn, Melville, Bell & Katon, 2003). This highlights the need for more training and more regular and consistent use of maternal mental health screening devices before, during, and after pregnancy. Below are resources and recommendations to address perinatal depression.

Recommendations for Standards of Care Guidlines from The National Association of Perinatal Social Workers

Website: http://napsw.org
Standards for Perinatal Social Workers Working with Patients Experiencing Postpartum Depression (2009) http://www.napsw.org/about/pdfs/postpartum-depression-standards.pdf

This resource suggests 10 standards of care for social workers (or other staff working with women) to use when assessing for PD.

- Provide evidence based counseling and support systems
- Conduct full psychological assessment with all first time mothers that includes education about causes, symptoms and solutions for PD
- Assess, educate and support all women with a history of depression, anxiety or other mood disorder throughout the perinatal period
- Provide resources and referrals for ante- and postpartum women for culturally and linguistically appropriate, evidence-based treatment and services
- Provide referrals for support groups (culturally and linguistically appropriate)
- Provide partners and family members with information about the signs and symptoms of PD and assist women with accessing services
- Provide social workers credentialed with a Masters of Social Work (MSWs) in settings where women are seen past 2 weeks postpartum to screen all women through a standardized instrument or screening scale
- Participate in regular and ongoing trainings about PD
- Perinatal social workers should be included in policy formation and decision making regarding the assessment and treatment of PD
- Provide support and education to medical and support staff on PD

Resource Catalog for Perinatal Depression (PD)

U.S Preventive Task Force (USPSTF)

Website: http://uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm

Recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. Grade: B recommendation.

Recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient. Grade: C recommendation.

These recommendations apply to nonpregnant adults, including older adults. It does not apply to children and adolescents, who are considered a separate population.

The Commonwealth Fund

Website: http://commonwealthfund.org
Parental Depression Screening for Pediatric Clinicians Implementation Manual (2007).

Website: http://www.commonwealthfund.org/Publications/Fund-Manuals/2007/Apr/Parental-Depression-Screening-for-Pediatric-Clinicians--An-Implementation-Manual.aspx

This resource provides information on when and who to screen, choosing a screening tool, exploring available resources, establishing triage and referral mechanisms, and developing an office system (train staff, system to distribute screening and results, and office environment). It is particularly useful for walking a healthcare practice through the stages needed to identify, motivate and train staff, as well as developing your screening/referral process and setting up a clear office system for doing so. Tool 1. Example of a Referral Care Pathway Model (pg 119) has a helpful chart for helping you work through preparing your practice and implementing PD screening. This can be adapted to include IPV screening along with PD.

American Congress of Obstetricians and Gynecologists (ACOG)

Website: http://acog.org
American Congress of Obstetrics and Gynecology Committee Opinion No. 453 (February 2010)
Website: http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Screening_for_Depression_During_and_After_Pregnancy

While ACOG suggests that there is insufficient evidence to support universal screening, ACOG strongly suggests that it should be considered

given the potential benefit to a woman and her family. Follow-up evaluation and treatment with positive screens must be done and a referral process should be available for those identified cases of depression.

This document also references possible choices for screening tools, including the number of questions, approximate time to administer and sensitivity/specificity.

The Institute of Medicine (IOM)

Website: http://www.iom.edu/
Clinical Preventive Services for Women: Closing the Gaps (2011)
Website: http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx

This report defines preventive health services, a centerpiece of the Patient Protection and Affordable Care Act of 2010 as "measures—including medications, procedures, devices, tests, education and counseling—shown to improve well-being, and/or decrease the likelihood or delay the onset of a targeted disease or condition." The IOM recommends that preventive services for women include 1) improved screening for cervical cancer, counseling for sexually transmitted infections, and counseling and screening for HIV; 2) a fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes; 3) services for pregnant women including screening for gestational diabetes and lactation counseling and equipment to help women who choose to breastfeed do so successfully; 4) at least one well-woman preventive care visit annually for women to receive comprehensive services; and 5) screening and counseling for all women and adolescent girls for interpersonal and domestic violence in a culturally sensitive and supportive manner.

Agency for Healthcare Research and Quality (AHRQ), Innovative Solutions

Website: http://www.innovations.ahrq.gov/index.aspx
Family Violence Prevention Program Significantly Improves Ability to Identify and Facilitate Treatment for Patients Affected by Domestic Violence
Website: http://www.innovations.ahrq.gov/content.aspx?id=2343

This profile of Kaiser Permanente Northern California's Family Violence Prevention Program highlights the programs approach to improving the identification, prevention, and intervention for domestic violence through a "systems model" approach. The program's components include: creating a supportive environment that encourages identification; routine, physician-led inquiry; referral to onsite mental health resources; and linkages to community resources.

American Academy of Pediatrics (AAP), Bright Futures

Website: http://brightfutures.org
Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents (2nd ed., rev)

Bright Futures (consistent with AAP and AAPD) standards suggest that pediatricians should support families as part of their role providing health care to children. The Bright Futures Guidelines include questions and anticipatory guidance that health care professionals can use to assess parental well-being. Specific questions are provided to assess depressive symptoms and are tailored for use at the prenatal, newborn, first week, one-month and two-month visits.

American Academy of Pediatrics (AAP) and American Congress of Obstetricians and Gynecologist (ACOG) Guidelines for Perinatal Care

Website: http://www.acog.org

This resource provides guidelines for perinatal care. This resource suggests that OB/GYN and pediatricians monitor the mother-child bonding. A way to assess this is to screen for maternal depression before, during and after pregnancy at OB/GYN visits. Pediatricians assess during pediatric visits (postpartum).

Prior to delivery, patients should be informed about psychosocial issues that may occur during pregnancy and in the postpartum period. A woman experiencing negative feelings about her pregnancy should receive additional support from the health care team. All patients should be monitored for symptoms of severe postpartum depression and offered culturally appropriate treatment or referral to community resources. Specifically, the psychosocial status of the mother and newborn should be subject to ongoing assessment after hospital discharge. Women with postpartum blues should be monitored for the onset of continuing or worsening symptoms because these women are at high risk for the onset of a more serious condition. The postpartum visit at approximately 4-6 weeks after delivery should include a review of symptoms for clinically significant depression to determine if intervention is needed.

Tools Available to Address Multiple Risk Factors Together

While interventions to address intimate partner violence (IPV) and perinatal depression (PD) vary, research supports that integrated risk interventions, delivered during pregnancy, are shown to reduce several risk factors during the postpartum period. One study found that addressing smoking, tobacco exposure, depression, and intimate partner violence together had positive effects on reducing such risks in the postpartum period (El-Mohandes et al., 2008).

Screening for both IPV and PD at the same time can be time-saving and helpful for both patients and providers. There are at least three tools that screen for both intimate partner violence and perinatal depression: the Antenatal Psychosocial Health Assessment (ALPHA), the Institute for Health and Recovery's (IHR) Behavioral Health High Risk Screening Tool, and the Preconceptional Screening and Assessment Project (PSAP) Integrated Screening Tool. A list of additional screening tools can be found in Table 1. Screening Tools for IPV and PD (pg 118).

The ALPHA is a 32-item questionnaire administered in a primary care setting that incorporates various risk factors for poor postpartum outcomes, such as child or woman abuse, postpartum depression, couple dysfunction, and physical illness (Blackmore, Carroll, Reid, Biringer, Glazier, Midmer, Permaul & Stewart, 2006).

It is used to initiate discussions of sensitive issues and to aid clinicians in identifying areas of concern where the woman may benefit from additional support or resources (Blackmore et al., 2006). The assessment has shown to be well accepted by patients and clinicians and effective at identify risk factors, especially those associated with family violence (Blackmore et al., 2006). While Blackmore, et al. agreed that the ALPHA is valuable for detecting many risk factors during pregnancy, their studies found it to be less successful at identifying symptoms of depression, and therefore they concluded that ALPHA should be used in conjunction with a tool that specifically measures depression (e.g. the EPDS) (Blackmore et al., 2006).

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

The IHR Behavioral Health High Risk, is based on the 5P's (parents, partners, peers, past, present), a screening tool developed through grant funding to states by the Maternal and Child Health Bureau for the Alcohol Screening Assessment in Pregnancy (ASAP) Project (Grant No: H51MC00011).

The 5P's was adapted from Dr. Ewing's 4P's (parents, partners, past, present), which was used to assess risk factors for alcohol use/abuse among women. The 5P's modified questions about past and present, added questions related to drug-problems and additional risk factors for alcohol use during pregnancy, and included a Peer section (the 5th "p") (Kennedy, Finkelstein, Hutchins & Mahoney, 2004). The IHR, working with the Massachusetts Department of Public Health, further modified the tool to be used in community health centers across the state. The tool was expanded to include questions related to emotional health and violence, along with a preamble to prepare women to be asked sensitive questions (Watson, 2010). In their 2009-2010 perinatal care recommendation, the Massachusetts Health Quality Partners suggested that clinicians use the IHR Behavioral Health High Risk Screening Tool to assess psychosocial problems, depression, and alcohol and drug use among patients (Massachusetts Health Quality Partners, n.d.). Although neither this tool nor the 5P's has been validated or tested for specificity or sensitivity (Kennedy et al., 2004), the 5P's has been successfully utilized in many types of settings and well accepted by health care professionals. Additionally, there are several on-going projects that are using the Behavioral Health High Risk Screening Tool (Watson, 2010).

The Pre-conception Screening and Assessment Project (PSAP) Integrated Screening Tool, tests for depression, substance use, and domestic violence for women before they become pregnant.

The tool was developed in response to a comprehensive study of infant deaths in Boston in which a large gap in health services was determined to be due, in part, to failure in identifying behavioral risks among reproductive age woman. The Project, entitled "Screening for Multiple Behavioral Risk Factors During Pre-Conception Through Postpartum Period," was funded by the HRSA Maternal and Child Health Bureau (Grant No: D63MC00050). It was a collaboration between community health centers, public health agencies, and representatives from academia. PSAP was intended to develop the capacity of community health centers to screen for depression, domestic violence and substance abuse; provide effective initial assessment and care in the primary care setting; and provide appropriate referrals (Engler, Gottlieb & Hutchins, 2007).

In addition to creating Standards of Care Guidelines and utilizing screening and referral tools, documentation, coding and connecting clients to services are extremely important in creating a continuum of care. "Accurate documentation provides several benefits: continuity of care, legal evidence collection, justification for specific clinical recommendations, reimbursement for services, protection from malpractice claims and improved understanding of the impact of domestic violence" (Rudman, 2000).

The Maryland Health Care Coalition Against Domestic Violence suggests the following regarding provider documentation:

- Record patient's account of how injury was inflicted and by whom (in quotes preferred).

- Avoid judgmental words (e.g. “alleged” assault). Use “patient reports…” instead of “patient alleged…” and “patient states” rather than “patient claims.”
- Document clinical observation: Record size, location, appearance, color of injury or marks. (May state, “injury consistent with patient’s account” without definitely attesting to how the injury was received).
- Document patient’s report of pain.
- Use photo documentation of injuries and/or body maps.
- Record contact with Sexual Assault Forensic Examiners (SAFE), police, courts, and other agencies.

(Maryland Health Care Coalition Against Domestic Violence, n.d.)

There are however serious risks to appropriate documentation and coding, as there is always a risk of disclosure of medical information and increased abuse (Rudman, 2000). In addition, the codes for diagnoses are currently set to change in October of 2013. Diagnosis codes impact all organizations covered by the Health Insurance Portability and Accountability Act (HIPAA), and can impact Medicare and Medicaid Services. For specific information concerning documentation and coding, visit the following resources:

- Centers for Medicare and Medicaid Services.

  Website: http://www.cms.gov/
- Health Privacy Principles for Protecting Victims of Domestic Violence from Futures Without Violence.

  Website: http://www.futureswithoutviolence.org/section/our_work/health/_health_material/_health_privacy
- Coding and Documentation of Domestic Violence from Futures Without Violence.

  Website: http://www.futureswithoutviolence.org/userfiles/file/HealthCare/codingpaper.pdf

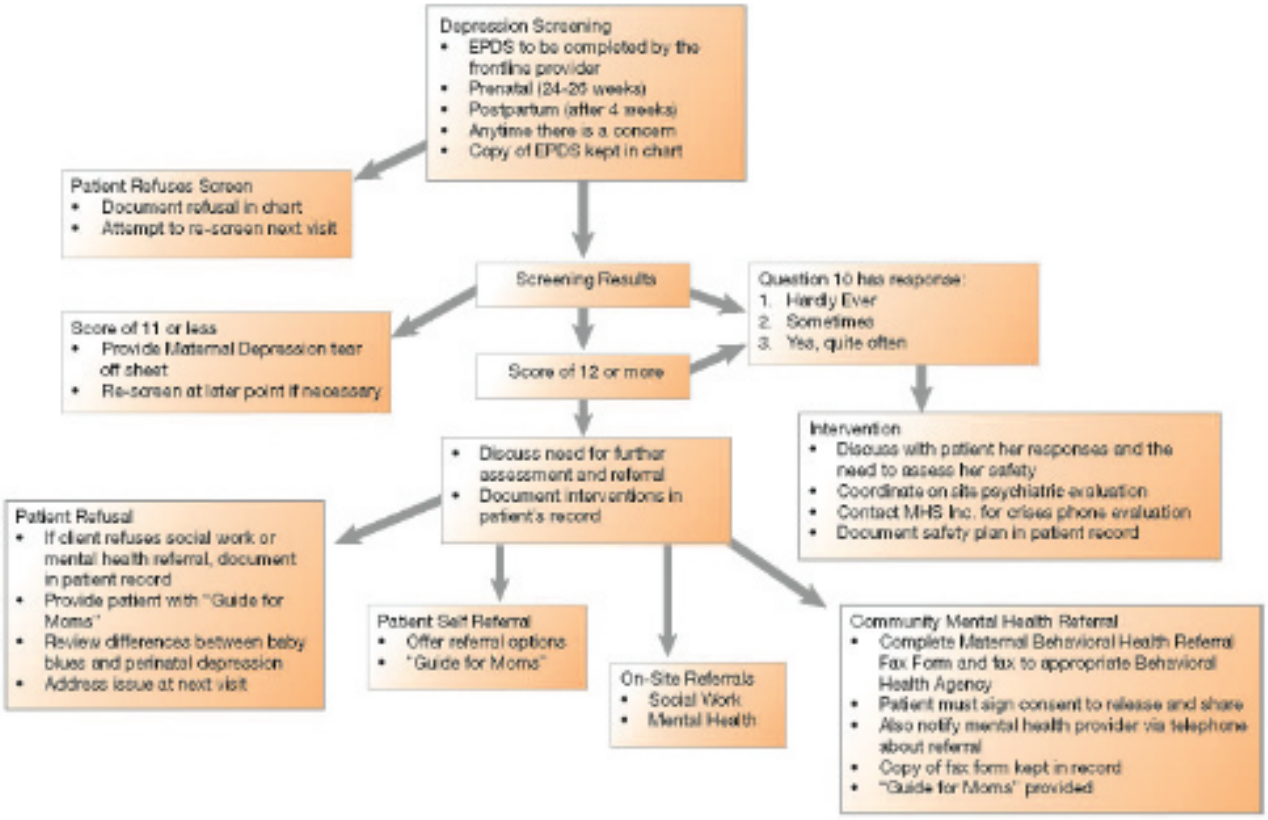
It is important to keep in mind that screening and referral tools may only be effective to the point clients are actually connected with the services they need. Organizations may choose to integrate screening, referrals, and service provision in many different ways. This resource catalog provides organizations with examples of standards of care, screening tools, and service implementation techniques; yet each organization must determine their readiness, ability, and resources to implement such tools – each organization’s needs and goals are unique and will not necessarily benefit from a one-size-fits-all approach. What’s important to remember is that screening and referrals should be accompanied by documentation, coding, and reporting as necessary, appropriate responses to the client’s situation, access to and provision of medical care, follow up appointments, and timely re-assessments (Family Violence Prevention Fund, 2002).

Table 1. Screening Tools for IPV and PD

Screening Tool	Target Population	Risk Factors Assessed	Source
Antenatal Psychosocial Health Assessment (ALPHA)	Pregnant women	• Child abuse • Women abuse • Postpartum depression • Couple dysfunction • Physical illness	Website: http://www.ocfp.on.ca/docs/research-projects/improving-the-odds-appendix.pdf?sfvrsn=2
Institute for Health and Recovery's (IHR) Behavioral Health High Risk Screening Tool	Pregnant women	• Emotional problems • Alcohol, tobacco, and drug use • Domestic violence	Website: http://www.healthrecovery.org/about_us/publications/Evolution%20&%20Application%20of%20the%205%20P'S%20(2010).pdf
Preconceptional Screening and Assessment Project (PSAP) Integrated Screening Tool	Reproductive age women in preconception period	• Depression • Alcohol, tobacco, and drug use • Domestic violence	Website: http://mhqp.org/guidelines/perinatalpdf/psap-integratedscreeningtool.pdf
Women Abuse Screening Tool (WAST)	Women patients at family practices	• Physical, sexual, and emotional abuse	Website: http://www.healthyplace.com/psychological-tests/woman-abuse-screening-tool/
Women's Experiences with Battering Scale (WEB)	Women in clinical settings	• Battering which may include but not be limited to physical, sexual and emotional abuse	Website: http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf
Composite Abuse Scale (CAS)	Women in clinical settings	• Physical, emotional, and combined abuse and harassment	Website: http://www.gp.unimelb.edu.au/about/docs/KH_CompositeAbuseScaleblurb.pdf
Edinburgh Postnatal Depression Scale (EPDS)	Pregnant or postpartum women	• Perinatal depression	Website: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Tool 1. Example of a Referral Care Pathway Model

Cleveland Regional Perinatal Network (CRPN)
Perinatal Depression Screening and Referral Carepath (Albaugh, n.d.)



ADDITIONAL RESOURCES: HOTLINES AND WEBSITES

Hotlines

National Domestic Violence Hotline
1-800-799-SAFE (7233)

Rape Abuse & Incest National Network Hotline (RAINN)
1-800-656-HOPE (4673)

Postpartum Support International (not a crisis hotline and does not handle emergencies)
1-800-944-4PPD

National Suicide Prevention Hotline
1-800-273-TALK (8255)

Websites

Centers for Disease Control and Prevention
Website: http://www.cdc.gov/violenceprevention/nisvs

Futures without Violence (formerly known as Family Violence Prevention Fund)
Website: http://www.futureswithoutviolence.org

National Coalition against Domestic Violence
Website: http://www.ncadv.org

National Network to End Domestic Violence
Website: http://www.nnedv.org/

National Resource Center on Domestic Violence
Website: http://www.nrcdv.org

Office on Violence Against Women (U.S. Department of Justice)
Website: http://www.ovw.usdoj.gov/

National Guidelines Clearinghouse
Website: http://www.guidelines.gov

Perinatal Depression Information Network

Website: http://www.pdinfonetwork.org

U.S. Department of Health and Human Services, Office on Women's Health

Website: http://www.womenshealth.gov

Postpartum Support International

Website: http://www.postpartum.net

National Mental Health Association

Website: http://www.nmha.org/

SAMHSA National Mental Health Information Center

Website: http://www.samhsa.gov/

National Women's Health Information Center

Website: http://www.womenshealth.gov/

National Institute of Mental Health

Website: http://www.nimh.nih.gov

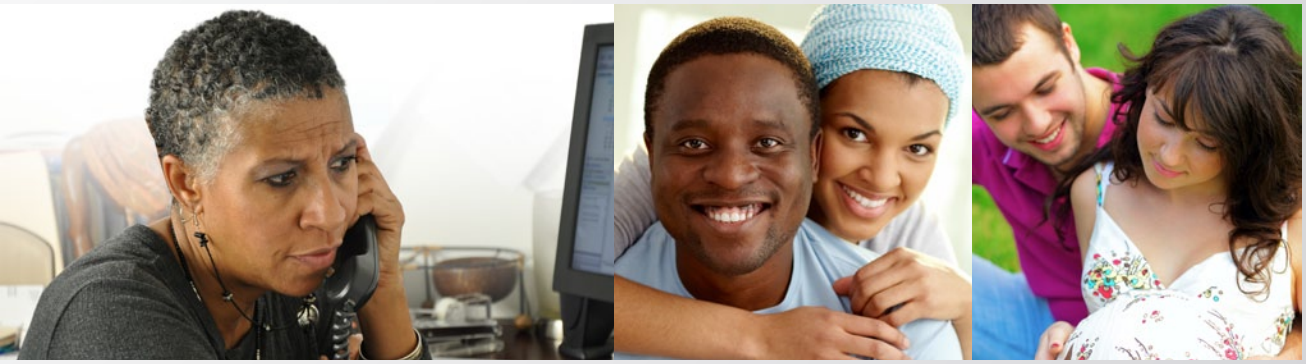
American Congress of Obstetricians and Gynecologists (ACOG)

Website: http://www.acog.org/

* This publication lists non-federal resources in order to provide additional information to consumers. The views and content in these resources have not been formally approved by the U.S. Department of Health and Human Services (HHS) or the Health Resources and Services Administration (HRSA). Listing these resources is not an endorsement by HHS or HRSA.

NOTES PAGE

Section 8



EVALUATION OF YOUR EFFORTS

STRATEGIC OVERVIEW

It is important to evaluate the success of your efforts by gathering feedback and information. Evaluation of your efforts can take many forms and include varying levels of difficulty. Below you will find some general strategies for how you can measure the success of your efforts.

Evaluation can take many forms, but generally it will help you:

- Assess how well your IPV/PD initiative is working
- Gather feedback, data, and information about your initiative and its activities that you can share with funders and members of your community
- Define success for your community

Why is evaluation important?

In addition to helping you determine how effective your work is, evaluation can provide these advantages:

- Assists in securing money and in-kind resources for the initiative
- Garners community support for and involvement in the initiative
- Generates ideas about how the initiative can be more effective
- Helps to overcome resistance to the initiative

How can success be measured?

These are some of the ways you can evaluate your effort:

- Telephone survey - an opportunity to measure community opinion regarding various issues related to your initiative.
- Survey of goals - a paper-pencil survey distributed to community members by mail that asks them to rate the importance and feasibility of your community-based initiative's goals.
- Mapping - an assessment ("map") that describes geo-spatial dimensions important to your initiative. For example, you may want to explore the relationship between location and quality of services available to treat IPV/PD and to note challenges associated with certain geographical subtypes (e.g., urban vs. rural) and related elements (e.g., cost, accessibility, or treatment quality).
- Survey of satisfaction - a paper-pencil survey distributed to members of the initiative that asks them to rate their satisfaction with issues such as the leadership, community involvement, and planning of your community-based initiative.
- Behavior survey(s) - a paper-pencil survey distributed annually to your target population to

assess their knowledge, attitudes and behaviors in relation to your goal. (For example, you may want to survey women who utilize your IPV/PD services to gauge their knowledge, attitude and behaviors).

- Interviews with key participants - semi-structured focus group interviews that clarify important events in the life of the initiative and illustrate the value that the initiative has added to the community.
- Survey of outcomes - a paper-pencil survey that asks initiative members, funders, and outside experts to comment on and rate the significance of changes made in the community.
- Goal attainment reports - reports that identify progress toward proposed changes identified in the action plan.
- On-line documentation system - an Internet-based system that gathers information regarding the daily activities of the initiative, including community actions, community changes, and services provided.
- Community-level indicators - information relevant to your initiative that is collected from local, state- or regional-level sources. (For example, you may want to gather statistics about rates of IPV or PD in your state or region that might already be available and track any changes that occur throughout the years).

The following tools, Tool 1. Post-Program Assessment and Tool 2. Recommendations for Improvement will help your organization assess challenges and successes in implementing strategies to address IPV/PD. Tool 1. guides you through questions related to each section of this toolkit and Tool 2. provides a chart for organizing any recommendations as you continue to address IPV/PD.

Tool 1. Post-Program Assessment

The following is adapted with permission from The Community Toolbox from the KU Workgroup for Community Health and Development (2010) and is helpful information to consider when evaluating your efforts. For more information, please visit The Community Toolbox on the web at http://ctb.ku.edu/en/default.aspx

Please use this post-program assessment after your organization has used this toolkit and implemented efforts around IPV/PD. For many programs the post-assessment should occur 6 months to a year after beginning your IPV/PD work, and then again at specified points in time as decided by the organization. You should also note who is completing the assessment and the date of completion. This assessment is meant for you to reflect on the efforts you've made, the challenges you still face, and consider what else you could do to successfully address IPV/PD.

Those completing the tool are encouraged to ask other staff questions to which they do not know the answer (or have multiple staff complete the tool for a variety of opinions).

Meet with the staff to review the results of the assessment. The discussion of this tool could be the topic of a staff meeting where all can provide input and strategies for improvement. The meeting facilitator could ask staff members which of the items highlighted by the tool could be changed easily, which they would like to change, and which the team should prioritize. An action plan could be developed based on the items that staff members identify as feasible, realistic, and most important to providing IPV/PD services.

I. Staff

1. What is the organization's knowledge and experience with intimate partner violence (IPV) and perinatal depression (PD)?

   _____

   _____

   _____

   _____

2. Have there been improvements in awareness towards addressing IPV/PD among staff at the organization?

   ☐ Yes ☐ No

3. Have there been improvements in knowledge towards addressing IPV/PD among staff at the organization?

   ☐ Yes ☐ No

4. Have there been improvements in positive attitudes towards addressing IPV/PD among staff at the organization?

   ☐ Yes ☐ No

If yes, what are the improvements and what do you think most contributed to these improvements? If no, what could be done to increase positive attitudes?

_____

_____

_____

5. Is IPV/PD a part of new staff training at the organization?

   ☐ Yes ☐ No

6. Is IPV/PD a part of continuing training at the organization?

   ☐ Yes ☐ No

7. If the organization has implemented IPV/PD training, how effective do you think the training was for your staff (please differentiate leadership vs. other staff)?

   _____

   _____

   _____

   _____

8. Has there been a change in the way staff provide services?

   _____

   _____

   _____

   _____

9. How confident are you that staff can apply new skills learned in training?

Not Confident	Somewhat Confident	Confident	Very Confident
☐	☐	☐	☐

10. Based on your understanding of IPV/PD, what policies and procedures support staff in providing quality services to persons living with IPV/PD?

    _____

    _____

    _____

    _____

II. Guidelines/procedures

1. Are there guidelines and procedures in place for assessing clients who are experiencing IPV/PD?

   ☐ Yes ☐ No (If no, skip to question 4)

2. Are there guidelines and procedures in place for referring clients who are experiencing IPV/PD?

   ☐ Yes ☐ No

3. Are there guidelines and procedures in place for treating clients who are experiencing IPV/PD?

   ☐ Yes ☐ No

4. What policies and procedures are barriers to staff providing quality services to persons experiencing IPV/PD?

   _____

   _____

   _____

   a. Has the organization implemented any procedures for addressing these barriers?

      _____

      _____

      _____

5. What guideline/policy changes has the staff made over the past year to make services more accessible to persons experiencing IPV/PD?

   _____

   _____

   _____

   _____

6. How might your organization make adjustments or improvements regarding the guidelines/policies in place?

   _____

   _____

   _____

III. Referrals and Participant Feedback

1. Do staff routinely refer participants to other programs or organizations for IPV/PD services?

   ☐ Yes ☐ No (If no, skip to question 3)

   If yes, to which programs/organizations does the organization routinely refer participants?

   a. _____

   b. _____

   c. _____

   d. _____

2. What processes do you have in place to ensure the referral is completed?

   _____

   _____

   _____

   _____

3. What processes does the organization have in place to collect feedback from participants about its services?

   _____

   _____

   _____

   _____

IV. Partnerships

1. What partnerships with community or public agencies exist to provide high quality services to its participants, specifically related to IPV/PD?

   a. _____

   b. _____

   c. _____

   d. _____

2. Has the organization been able to build a referral and/or partnership network?

   ☐ Yes ☐ No

3. Has the organization developed a Referral Care Pathway?

   ☐ Yes ☐ No

4. How have the partnerships helped the organization meet the goals around addressing IPV/PD?

5. What could be done to improve the organization's partnerships?

V. Raising Awareness

1. Is the organization participating in a public IPV/ PD awareness campaign within your community?

   ☐ Yes ☐ No

   If yes, what is the campaign?
   If no, why not participate?

2. Does the organization have guidelines and a clear process for how to effectively work with local media?

   ☐ Yes ☐ No

   If yes, what are the guidelines/processes?
   If no, why are there not guidelines/processes in place?

3. Do you feel that awareness about IPV/PD has increased among **staff**?

   ☐ Yes ☐ No

4. Do you feel that awareness about IPV/PD has increased among your **partnering agencies**?

   ☐ Yes ☐ No

5. Do you feel that awareness about IPV/PD has increased with the **public in general**?

   ☐ Yes ☐ No

6. Does the physical environment (clinic/office) have culturally competent posters, brochures or awareness materials related to IPV/PD?

   ☐ Yes ☐ No

7. Does the organization have a section of the website dedicated to information about IPV/PD?

   ☐ Yes ☐ No

8. What has prevented the organization from more effectively raising awareness and what steps could you take to improve your awareness efforts?

   _____

   _____

   _____

   _____

VI. Cultural Competency

1. Do staff represent the cultures and languages of your target population?

   ☐ Yes ☐ No

   a. What cultures and languages are represented among your staff?

      _____

      _____

      _____

2. Do people of different cultures interact with the organization and utilize the services?

   ☐ Yes ☐ No

3. Does the organization provide information in staff trainings about the cultures, beliefs and stigmas that may be associated with families using your services?

   ☐ Yes ☐ No

   If yes, please describe the training.
   If no, how could this information be incorporated into existing trainings?

   _____

   _____

   _____

4. Does the physical environment of the organization's clinic/office have posters, brochures or awareness materials that are culturally and linguistically competent?

   ☐ Yes ☐ No

5. Does the organization provide bi-lingual services?

   ☐ Yes ☐ No

6. Does your organization have a language access plan that includes plans for access to a language line and/or interpreters?

   ☐ Yes ☐ No

7. Is the organization currently conducting bi-lingual outreach within the community?

   ☐ Yes ☐ No

8. Does the organization have a relationship with culturally specific community-based service providers in the area?

   ☐ Yes ☐ No

   a. If yes, do you have a Memorandum of Understanding (MOU) signed?

      ☐ Yes ☐ No

      _____

      _____

      _____

   b. If yes, do you refer clients to these organizations?

      ☐ Yes ☐ No

      _____

      _____

      _____

9. Describe how the organization's efforts to promote cultural inclusion have been successful.

   _____

   _____

   _____

VII. Standards of Care

1. Does the organization utilize Standards of Care Guidelines for IPV and PD?

   ☐ Yes ☐ No

   If yes, what guidelines are you currently using?
   If no, what has prevented the organization from adopting these guidelines?

   _____

   _____

   _____

   _____

2. Has the organization chosen a standard screening tool to use in practice?

   ☐ Yes ☐ No

   a. If yes, does the tool address both IPV and PD or do you need to use two separate screening tools?

      ☐ Addresses Both ☐ Need Two Separate Tools

3. Have staff been trained in how to screen women for IPV/PD using the Standards of Care guidelines and recommended techniques?

   ☐ Yes ☐ No ☐ Not Applicable

   _____

   _____

   _____

4. Describe how the organization's efforts to identify and utilize Standards of Care guidelines and standard screening tools have or have not been successful.

   _____

   _____

   _____

Tool 2. Recommendations for Improvement

Please take a moment and think about changes that could help your program better address intimate partner violence and perinatal depression. Give your recommendations in any or all of the areas in the table below. Include your ideas for how this aspect of your program can be improved. Feel free to copy this form and ask staff about their perspectives and recommendations. You can discuss the results and use the recommendations to prioritize areas to focus on in the future. This tool can be completed at 6 month intervals or whenever your organization feels it is important or necessary to visit/re-visit.

Area of Interest	Do You Recommend Change in This Area?	Recommendations (please describe)
Staff Training for IPV/PD	Yes No Don't Know	
Agency Guidelines for Assessing IPV/PD	Yes No Don't Know	
Agency Guidelines for Referring for IPV/PD	Yes No Don't Know	
Agency Guidelines for Treating IPV/PD	Yes No Don't Know	
Partnerships and Referrals	Yes No Don't Know	
Number of Resources Available to Staff	Yes No Don't Know	
Raising Awareness among Staff	Yes No Don't Know	
Raising Awareness among the Public or Key Stakeholders	Yes No Don't Know	
Raising Awareness Efforts with the Local Media	Yes No Don't Know	

Area of Interest	Do You Recommend Change in This Area?	Recommendations (please describe)
IPV/PD Materials (posters, brochures, website etc)	Yes No Don't Know	
Providing Materials that are Culturally and Linguistically Appropriate	Yes No Don't Know	
Providing Services that are Culturally and Linguistically Appropriate	Yes No Don't Know	
Identifying and Utilizing Standards of Care Guidelines for screening, referral and treatment of IPV/PD	Yes No Don't Know	
The Current Action Plan in Place to Address IPV/PD	Yes No Don't Know	

REFERENCES

Abraham, M. (2000). Speaking the unspeakable: Marital violence among south Asian immigrants in the United States. New Brunswick, NJ: Rutgers University Press.

Albaugh, A. (2007). Cleveland Regional Perinatal Network: Perinatal depression screening and referral care path sample. Retrieved from http://crpn.net/wp/wp-content/uploads/2011/11/CRPNCarepath2007rev09rev11.pdf

American Academy of Pediatrics (AAP) & American Congress of Obstetricians and Gynecologists (ACOG). (2007). *Guidelines for perinatal care*. (6th ed.). Elk Grove Village, Ill.: American Academy of Pediatrics, and Washington, D.C.: American College of Obstetricians and Gynecologists.

American Congress of Obstetricians and Gynecologists. (2012). *Committee opinion on intimate partner violence, No. 518*. Retrieved from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/co518.pdf?dmc=1&ts=20121222T0037136605

American Congress of Obstetrics & Gynecology (2011). Frequently asked questions, labor, delivery and postpartum care, FAQ 091. Retrieved from http://www.acog.org/~/media/For%20Patients/faq091.pdf?dmc=1&ts=20130103T1501286118

American Congress of Obstetrics & Gynecology. (2010). Committee opinion no. 453: Screening for depression during and after pregnancy. *Obstetrics & Gynecology, 115, 394-395*

American Congress of Obstetricians and Gynecologists. (2009). Perinatal depression screening: Tools for obstetricians-gynecologists. Retrieved from http://mail.ny.acog.org/website/DepressionToolKit.pdf

American Congress of Obstetricians and Gynecologists (2007, May 7). The challenges of diagnosing and treating maternal depression: Women's health experts weigh in. [New Release] Retrieved from http://www.acog.org/About_ACOG/News_Room/News_Releases/2007/The_Challenges_of_Diagnosing_and_Treating_Maternal_Depression

Anderson, M. J. (1993). License to abuse: The impact of conditional status on female immigrants. *Yale Law Journal, 102*(6), 1401-30.

Arnow, B.A. (2004). Relationships between childhood maltreatment, adult health and psychiatric outcomes, and medical utilization. *Journal of Clinical Psychiatry, 65*, 10–15.

Asling-Momemi, K., Naved, R. T., & Persson, L.A. (2009). Violence against women and the risk of fetal and early childhood growth impairment: A cohort study in rural Bangladesh. *Archives of Disease in Childhood, 94*, 775-779. doi:10.1136/adc.2008.144444.

Begum, S., Dwivedi, S.N., Pandey, A., & Mittal, S. (2010). Association between domestic violence and unintended pregnancies in India: Findings from the National Family Health Survey-2 data. *Women's Health Issues, 20*(2), 96-104.

Betancourt, J.R. Green, A.R., & Carrillo, J.E. (October 2002). Cultural competence in health care: Emerging frameworks and practical approaches: Field report. Retrieved from http://www.azdhs.gov/bhs/pdf/culturalComp/cchc.pdf

Blackmore, E.R., Carroll, J., Reid, A., Biringer, A., Glazier, R.H., Midmer, D., Permaul, J.A. & Stewart, D.E. (2006). The Use of the Antenatal Psychosocial Health Assessment (ALPHA) Tool in the detection of psychosocial risk factors for postpartum depression: A randomized controlled trial. *Journal of Obstetrics and Gynecology Canada 28*(10), 873–878

Bohn, D. K., Tebben, J. G., & Campbell, J. C. (2004). Influences of income, education, age, and ethnicity on physical abuse before and during pregnancy. *Journal of Obstetrics, Gynecologic and Neonatal Nursing, 33*, 561-571.

Buist, A., Condon, J., Brooks, J., Speelman, C., Milgrom, J., Hayes, B., Ellwood, D., Barnett, B., Kowalenko, N., Matthey, S., Austin, MP., & Bilszta, J. (2006). Acceptability of routine screening for perinatal depression. *Journal of Affective Disorders, 93*(1), 233-237.

Burt, V.K., & Quezada, V. (2009). Mood disorders in women: Focus on reproductive psychiatry in the 21st century--Motherisk update 2008. *Canada Journal of Clinical Pharmacology, 16*(1), e6-e14.

California Clinical Forensic Medical Training Center (CCFMTC). (2004). Legal requirements for reporting domestic violence. Retrieved from http://ccfmtc.org/pdf/Legal_Requirements_for_Reporting.pdf

Casey, P., Goolsby, S., Berkowitz, C., Frank, D., Cook, J., Cutts, D., Black, M.M., Zaldivar, N., Levenson, S., Hereen, T., & Meyers, A. (2004). Maternal depression, changing public assistance, food security, and child health status. *Pediatrics, 113*(2), 298-304.

Catalano, S. (2007). U.S. Department of Justice. Office of Justice Programs. Bureau of Justice Statistics: Intimate partner violence in the United States. Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/ipvus.pdf

Centers for Disease Control (CDC). (2008). Prevalence of self-reported postpartum depressive symptoms—17 states, 2004- 2005. *MMWR Weekly 57*(14), 361-366. Retrieved from http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5714a1.htm

Centers for Disease Control and Prevention (CDC). (2010a). Intimate partner violence: Definitions. Retrieved from http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html

Centers for Disease Control and Prevention (CDC). (2010b). Depression among women of reproductive age and postpartum depression. Retrieved from http://www.cdc.gov/reproductivehealth/Depression/index.htm

Centers for Disease Control and Prevention (CDC), National Center for Injury and Prevention Control, Division of Violence Prevention. (2011). National intimate partner and sexual violence survey. Retrieved from http://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf

Centers for Disease Control and Prevention (CDC). (2012). Understanding intimate partner violence. Retrieved from http://www.cdc.gov/ViolencePrevention/pdf/IPV_Factsheet-a.pdf

Cerulli, C., Talbot, N.L., Tang, W. & Chaudron, L.H. (2011). Co-Occurring intimate partner violence and mental health diagnoses in perinatal women. *Journal of Women's Health 20*(12), 1797-1803. doi:10.1089/jwh.2010.2201.

Chang, J., Berg, C., Saltzman, L., & Herndon, J. (2005). Homicide: A leading cause of injury deaths among pregnant and postpartum women in the United States, 1991–1999. *American Journal of Public Health, 95*(3), 471-477.

Charles, P. & Perreira, K. (2007). Intimate partner violence during pregnancy and 1 year post partum. *Journal of Family Violence, 22*, 609–619. doi: 10.1007/s10896-007-9112-0.

Cheng, D. (March, 2012). *Intersection between perinatal depression and intimate partner violence*. Webinar presentation for the HRSA intimate partner violence and perinatal depression Resource Development Project.

Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a Culturally Competent System of Care, Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Dube, S.R., Anda, R.F., Whitfield, C.L., Brown, D.W., Felitti, V.J., Dong, M., & Giles, W.H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*, 430–438. Dunn, L. L., & Oths, K. S. (2004). Prenatal predictors of intimate partner violence. *Journal of Obstetrics, Gynecologic and Neonatal Nursing, 33*(1), 54-63. doi: 10.1177/0884217503261080

Dutton, M.A., Orloff, L., & Hass, G.A. (2000). Characteristics of help-seeking behaviors, resources, and service needs of battered immigrant Latinas: Legal and policy implications. *Georgetown Journal of Poverty, Law and Policy, 7*, 30-49.

Earls, M.F. & The Committee on Psychosocial Aspects of Child and Family Health (2010). Clinical report: Incorporating recognition and management of perinatal and postpartum depression into pediatric. *Pediatrics, 126*(5), 1032-1039. Retrieved from http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html

El-Mohandes, A.A., Kiely, M., Joseph, J.G., Subramanian, S., Johnson, A.A., Blake, S.M., Gantz, M.G., & El-Khorazaty, M.N. (2008). An intervention to improve postpartum outcomes in African American mothers: A randomized controlled trial. *Obstetrics & Gynecology, 2*(3), 611-620.

Engler, C, Hutchins, E, & Gottlieb, B. (2007). PSAP digital stories: Bringing women's experiences with depression into primary care. [Powerpoint] Retrieved from https://apha.confex.com/apha/135am/recordingredirect.cgi/id/18721

Epperson, N. (2002). Postpartum mood changes: Are hormones to blame? *Zero to Three, 22*(6), 17-23.

Family Violence Prevention Fund (2002). National consensus guidelines on identifying and responding to domestic violence victimization in health care settings. Retrieved from http://www.futureswithoutviolence.org/userfiles/file/Consensus.pdf

Field, C.A. & Caetano, R. (2005). Intimate partner violence in the U.S. general population: Progress and future directions. *Journal of Interpersonal Violence, 20*(4), 463-469. doi: 10.1177/0886260504267757

Field, T. (2010). Postpartum depression effects on early interactions, parenting, and safety practices: A review. *Infant Behavior and Development, 33*(1), 1-6.

Fiester, L. (2004). Putting the pieces together: *Comprehensive school-linked strategies for children and families*. Washington, DC: U.S. Department of Education.

Foa, E.B., Cascardi, M., Zoellner, L.A., & Feeny, N. (2000). Psychological and environmental factors associated with partner violence. *Trauma, Violence & Abuse, 1*(1): 67-91.

Futures without Violence. (2012). Get the facts: The facts on domestic, dating and sexual violence. Retrieved from http://www.futureswithoutviolence.org/content/action_center/detail/754

Futures without Violence. (2007). State codes on intimate partner violence victimization reporting requirement for healthcare providers. Retrieved from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/MandReport2007FINALMMS.pdf

Gao, W., Paterson, J., Abbott, M., Carter, S., & Iusitini, L. (2010). Pacific Islands families study: Intimate partner violence and postnatal depression. Journal of Immigrant & Minority Health, 12(2), 242-248. doi:10.1007/s10903-008-9190-y.

Gaynes, B.N., Gavin, N., Melzer-Brody, S., Lohr, K.N., Swinson, T., Gartlehner, G., Brody, S., & Miller, W.C. (2005). Perinatal depression: prevalence, screening, accuracy, and screening outcomes. *Summary, evidence report technology/ assessment No 119*. (Prepared by the RTI-University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). ARHQ publication No 05-E0006-1. Rockville, MD: Agency for Healthcare Research and Quality.

Gazmararian, J.A., Lazorick, S., Spitz, A.M., Ballard, T.J., Saltzman, L.E. & Marks, J.S. (1996). Prevalence of violence against pregnant women. *Journal of the American Medical Association, 275*(24), 1915-1920.

Gazmararian, J.A., Petersen, R., Spitz, A.M., Goodwin, M.M., Saltzman, L.E. & Marks, J.S. (2000).Violence and reproductive health: Current knowledge and future research directions. Maternal and Child Health Journal 4(2), 79-84. doi:10.1023/ A:1009514119423

Goode, T.D. & Sockalingam, S. (2000). Cultural competence: Developing policies To address the health care needs of culturally diverse clientele. *Home Health Care Management Practice 12*(5), 49-55. doi: 10.1177/108482230001200514

Hahm, H.C,. Lee, Y., Ozonoff, A., & Van Wert, M,J. (2010). The impact of multiple types of child maltreatment on subsequent risk behaviors among women during the transition from adolescence to young adulthood. *Journal of Youth and Adolescence, 39*(5), 528-40.

Halbreich, U. & Karkun, S. (2006). Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms. *Journal of Affective Disorders, 91*, 97 – 111.

Horowitz, J.A., Murphy, C.A., Gregory, K.E., & Wojcik, J. (2009). Best practices: Community-based postpartum depression screening: Results from the CARE study. *Psychiatric Services 60*, 1432-1434. Retrieved from http://psychservices.psychiatryonline.org/cgi/content/abstract/60/11/1432

Husain, M., Chaudhry, I., Saeed, Q., Khan, S., Hassan, Q., & Husain, N. (2009). P01-234 Social stress and depression during pregnancy in women of a low-income country. *European Psychiatry, 24*. doi:10.1016/S0924-9338(09)70855-7.

Jasinski, J.L. (2004). Pregnancy and domestic violence: a review of the literature. *Trauma, Violence & Abuse 5*(1), 47-64. doi:10.1177/1524838003259322

Kendell, R.E., Chalmers, J.C., & Platz, C. (May 1987). Epidemiology of puerperal psychoses. *British Journal of Psychiatry, 150*, 662-73.

Kennedy, C., Finkelstein, N., Hutchings, E. & Mahoney, J. (2004). Improving screening for alcohol use during pregnancy: The Massachusetts ASAP Program. *Maternal and Child Health Journal, 8*(3), 137-147.

Klap, R., Tang, L., Wells, K. Starks, S.L., & Rodriguez, M. (2007) Screening for domestic violence among adult women in the US. *Journal of General Internal Medicine, 22*, 579-584.

KU Work Group for Community Health and Development. (2010). The Community Toolbox. Lawrence, KS: University of Kansas. Retrieved from http://ctb.ku.edu/en/default.aspx

LaRocco-Cockburn, A., Melville, J., Bell, M., & Katon, W. (2003). Depression screening attitudes and practices among obstetrician-gynecologists. *Obstetrics & Gynecology, 101*, 892-898.

Leckman, J. & Herman, A. (2002). Maternal behavior and developmental psychopathology. *Biological Psychiatry, 51*(1), 27-43.

Lehman, J. & Shirelle, P. (Eds). (2005). West's Encyclopedia of American law (2nd ed.). Detroit, MI: Thomson/Gale. Marcus, S.M. (2009). Depression during pregnancy: rates, risks and consequences--Motherisk Update 2008. *Canadian Journal Clinical Pharmacology, 16*(1), 15-22.

Maryland Health Care Coalition Against Domestic Violence (n.d.). The health care response to domestic violence: Information for health care providers. Retrieved from http://healthymaryland.org/wp-content/uploads/2011/05/FINAL_Health-Care-Website.pdf

Massachusetts Department of Health and Human Services (n.d.). Home visiting initiative. Mass. home visiting program implementation update. Retrieved from http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/home-visiting/

Massachusetts Quality Health Partners (n.d.). 2009/10 Perinatal Care Recommendations. Retrieved from http://www.mhqp.org/guidelines/perinatal/perinatal.asp?nav=041200

Mathews, T.J., Menacker, F., & MacDorman, M.F. (2002). Infant mortality statistics from the 200 period linked birth/infant death data set. (National Vital Statistics Reports Vol. 50 No. 12). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_12.pdf

Mayberry, L. J., Horowitz, J. A., & Declercq, E. (2007). Depression symptom prevalence and demographic risk factors among U.S. women during the first 2 years postpartum. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36*(6), 542–549.

McDonnell, K.A., Burke, J.G., Gielen, A.C., & O'Campo, P.J. (2006). Intimate partner violence. In A.C. Gielen, D. Sleet, & R.J. DiClemente (eds), *Injury and Violence Prevention: Behavioral Science Theories, Methods, and Applications* (323-345). San Francisco, CA: Jossey-Bass.

McFarlane, J., Parker, B., & Soeken, K. (1996). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetrics, Gynecologic and Neonatal Nursing, 25*(4), 313−320.

Meltzer-Brody, S. (2011). New insights into perinatal depression: Pathogenesis and treatment during pregnancy and postpartum. *Dialogues in Clinical Neuroscience. 13*(1), 89–100. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181972/

Murray L, & Cooper P.J. (2006). Postpartum depression and child development. New York Medical News Today New Jersey Law Requiring Postpartum Depression Screening Goes Into Effect. Retrieved from http://www.medicalnewstoday.com/releases/54096.php

National Association of County and City Health Officials (NACCHO). (2008). Intimate partner violence among pregnant and parenting women: Local health department strategies for assessment, intervention, and prevention. Retrieved from http://www.naccho.org/topics/HPDP/mch/upload/IPV-Issue-Brief-6-11-08.pdf

National Center on Domestic Violence, Trauma, and Mental Health (NCDVTMH). (May 2011). Intimate partner violence and lifetime trauma. Retrieved from http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Warshaw-IPV-and-Lifetime-Trauma.pdf

National Institute for Health Care Management (NIHCM). (2010). Identify and treating maternal depression: Strategies & considerations for health plans. (NIHCM Foundation Issue Brief). Retrieved from http://nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf

Nelson, J., & Prescott, D. (2005). Partnering for success: Business perspectives on multistakeholder partnerships, World economic forum global corporate citizenship initiative. Retrieved June 9, 2010 from http://www.hks.harvard.edu/m-rcbg/CSRI/publications/report_4_FINAL_GCCI_PPP-Report_200105.pdf

O'Hara, M.W., Neunaber, D.J., & Zekoski, E.M. (1984). Prospective study of postpartum depression: Prevalence, course, and predictive factors. *Journal of Abnormal Psychology, 93*(2), 158-71.

Pallitto, C.C. & O'Campo, P. (2004). The relationship between intimate partner violence and unintended pregnancy: Analysis of a national sample from Colombia. *International Family Planning Perspectives, 30*(4), 165-73.

Penn, D. & Couture, S. (2002). Strategies for reducing stigma towards persons with mental illness. *World Psychiatry 1*(1), 20–21.

PostpartumMen (n.d.). Helping men beat the baby blues and overcome depression. Retrieved from http://www.postpartummen.com/

Raj, A. & Silverman, J. (2002). Violence against immigrant women: The roles of culture, context, and legal immigrant status on partner violence. *Violence Against Women, 8*(3), 367-398.

Rennison, C.M. & Welchans, S. (2000). Intimate partner violence. Bureau of Justice Statistics Special Report (NCJ 178247). Washington, DC: U.S. Department of Justice. Office of Justice Programs. Bureau of Justice Statistics. Retrieved from http://bjs.ojp.usdoj.gov/content/pub/pdf/ipv.pdf

Rich-Edwards, J. W., Kleinman, K., Abrams, A., Harlow, B. L., McLaughlin, T. J., Joffe, H., & Gillman, M. (2006). Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice. *Journal of Epidemiology and Community Health, 60*, 221–227.

Rodriguez, M., Bauer, H., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse. *The Journal of American Medical Association. 282*(5), 468-474.

Rodriguez, M., Valentine, J.M., Son, J.B. & Muhammad, M. (2009). Intimate partner violence and barriers to mental health care for ethnically diverse populations of women. *Trauma, Violence & Abuse, 10*(4): 358–374.

Rojas, G., Fritsch, R., Guajardo, V., Rojas, F., Barroilhet, S., & Jadresic, E. (2010). Characterization of depressed mothers in the postpartum. *Revista Medica de Chile, 138*(5), 536-42.

Ross, L.E., Steele, L., Goldfinger, C., and C. Strike, C. (2007). Perinatal depressive symptomatology among lesbian and bisexual women. *Archives of Women's Mental Health 10*(2), 53-59. Retrieved from http://www.springerlink.com/content/cq665362w60644g5/?MUD=MP

Rudman, W. J. (2000). Coding and documentation of domestic violence. Retrieved from http://www.futureswithoutviolence.org/userfiles/file/HealthCare/codingpaper.pdf

Saltzman, L.E., Fanslow, J.L., McMahon, P.M. & Shelley, G.A. (2002). Intimate partner violence surveillance: Uniform definitions and recommended data elements, version 1.0. Retrieved from http://www.cdc.gov/ncipc/pub-res/ipv_surveillance/intimate.htm

Scottish Intercollegiate Guidelines Network (SIGN). (2002). Postnatal depression and puerperal psychosis: A national clinical guideline. Publication No. 60. Retrieved from http://www.sign.ac.uk/guidelines/fulltext/60/index.html

Seehusen, D., Baldwin, L.M., Runkle, G., & Clark, G. (2005). Are family physicians appropriately screening for postpartum depression? *Journal of the American Board of Family Medicine, 18*(2), 104-112.

Segre, L. S., O'Hara, M. W., Arndt, S., & Stuart, S. (2007). The prevalence of postpartum depression: The relative significance of three social status indices. *Social Psychiatry and Psychiatric Epidemiology, 42*, 316–321.

Shoultz, J., Magnussen, L., Manzano, H., Arias, C., & Spencer, C. (2010). Listening to Filipina women: Perceptions, responses and needs regarding intimate partner violence. *Issues in Mental Health Nursing, 31*(1), 54-61.

Silverman, J.G., Raj, A., Mucci, L.A., & Hathaway, J.E. (2001). Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association, 286*, 572-577.

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006). Intimate partner violence victimization prior to and during pregnancy among women residing in 26 U.S. states: Associations with maternal and neonatal health. American Journal of Obstetrics and Gynecology, 195(1), 140-148.

Spitzer, R.L., Williams, J.B.W., Kroenke, K., Hornyak, R., & McMurray, J. (2000). Validity and utility of the PRIME-MD Patient Health Questionnaire in assessment of 3000 obstetric-gynecologic patients: The PRIME-MD Patient Health Questionnaire Obstetrics-Gynecology Study. *American Journal of Obstetrics and Gynecology*, 759- 769. Retrieved from http://www.nri-inc.org/projects/SDICC/WorkGroups/spitzer2.pdf

Stampfel, C. C., Chapman, D.A., & Alvarez, A.E. (2010) Intimate partner violence and posttraumatic stress disorder among high-risk women: does pregnancy matter? *Violence Against Women 16* (4), 426-443. doi: 10.1177/1077801210364047

Stroud, L., Niaura, R., Lagasse, L., Lester, B. (March, 2004). Maternal pre and postnatal depression influences cortisol responses in infants. Oral presentation to the American Psychosomatice Society Annual Meeting, Orlando, FL.

Taillieu, T.L., & Brownridge, D.A. (2010). Violence against pregnant women: Prevalence, patterns, risk factors, theories, and directions for future research. *Aggression and Violent Behavior 15*, 14–35.

The Center for Non-Profits. (2002). Nonprofit organizations can lobby. Retrieved from http://njnonprofits.org/NPsCanLobby.html

Tiwari, A., Leung, W., Leung, T., Humphreys, J., Parker, B., & Ho, P. (2005). A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. BJOG: *An International Journal of Obstetrics & Gynaecology, 112*(9), 1249-1256. doi:10.1111/j.1471-0528.2005.00709.x.

Tjaden P, Thoennes N. (1998). Stalking in America: Findings from the National Violence Against Women Survey. (NCJ 169592). Washington, DC: Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles/169592.pdf

Tjaden, P., Thoennes, N., & Allison, C.J. (1999). Comparing violence over the life span in samples of same-sex and opposite-sex cohabitants. *Violence and Victims 14*(4), 413 – 425

Tjaden, P. & Thoennes, N. (2000). Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey. (NCJ 181867). Washington, DC: National Institute of Justice/Centers for Disease Control and Prevention.

Trettin, S., Moses-Kolko, E.L. & Wisner, K.L. (2006). Lesbian perinatal depression and the heterosexism that affects knowledge about this minority population. *Archives of Women's Mental Health 9*(2), 67-73. doi:10.1007/s00737-005-0106-8

United Nations Children's Fund (UNICEF). (2005). Behind closed doors: The impact of domestic violence on children. Retrieved from http://www.unicef.org/protection/files/BehindClosedDoors.pdf

University of Minnesota, Center for Advanced Research on Language Acquisition (n.d.). What is culture? Retrieved from http://www.carla.umn.edu/culture/definitions.html

Uscher-Pines, L. & Nelson, D.B. (2010). Neighborhood and individual-level violence and unintended pregnancy. *Journal of Urban Health, 87*(4), 677-87.

U.S. Department of Health and Human Services (HHS). National Institutes of Health. Office of Behavioral and Social Sciences. (n.d.). Social and cultural factors in health. Retrieved from http://obssr.od.nih.gov/scientific_areas/social_culture_factors_in_health/index.aspx

U.S. Department of Health and Human Services (HHS). Health Resources and Services Administration (HRSA). (2002). Healing shattered lives: An assessment of selected domestic violence programs in primary health care settings. Retrieved from ftp://ftp.hrsa.gov/bphc/pdf/omwh/domesticviolence.pdf

U.S. Department of Health and Human Services. Office of Women's Health (OWH). (2009). Violence against women. Retrieved from http://www.womenshealth.gov/violence/

U.S. Department of Health and Human Services (HHS). Health Resources and Services Administration (HRSA). (2012). Healthy Start Initiative: eliminating disparities in perinatal health (general population). Funding opportunity announcement (HRSA-12-016), fiscal year 2012.

U.S. Government Accountability Office (GAO). (2002). Violence against women: Data on pregnant victims and effectiveness of prevention strategies are limited. GAO-02-530. Washington, DC: Government Accountability Office. Retrieved from http://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-02-530/html/GAOREPORTS-GAO-02-530.htm

U.S. Internal Revenue Services (IRS). (2012). Political campaign intervention by 501(c)(3) tax-exempt organizations - educating exempt organizations. Retrieved from http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Political-Campaign-Intervention-by-501(c)(3)----Tax-Exempt-Organizations-Educating-Exempt-Organizations

U.S. Preventive Services Task Force (USPSTF). (2009). Screening for depression in adults: U.S. Preventive Services Task Force recommendation statement. *Annals of Internal Medicine, 151*(11), 784-92.

Valentine, J.M., Rodriguez, M.A., Lapeyrouse, L.M. & Zhang, M. (2011). Recent intimate partner violence as a prenatal predictor of maternal depression in the first year postpartum among Latinas. *Archives of Women's Mental Health 14*, 135–143. doi 10.1007/s00737-010-0191.

Violence Against Women Online Resources.(n.d.) Reviewing domestic violence fatalities: Summarizing national developments. Retrieved from http://www.vaw.umn.edu/documents/fatality/fatality.html

Waalen, J., Goodwin, M.M., Spitz, A.M. Petersen, R., & Saltzman, L.E. (2000). Screening for intimate partner violence by health care providers: Barriers and interventions. *American Journal of Preventive Medicine, 19*(4), 230-237.

Warshaw, C. & Barnes, H. (2003). Domestic violence, mental health & trauma: Research highlights: The Domestic Violence and Mental Health Policy Initiative. Retrieved from http://www.vawnet.org/summary.php?doc_id=612&find_type=web_sum_GC

Watson, E. (2010). The evolution and application of the 5 P'S Behavioral Risk Screening Tool. In A. Price & J. Pietrzak (Eds). *The Source, 20*(2), 27-29. Retrieved from http://aia.berkeley.edu/media/pdf/SourceFall2010.pdf

World Health Organization (WHO). (n.d.) Intimate partner violence and alcohol fact sheet. Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf

Yost, N. P., Bloom, S. L., McIntire, D. D., & Leveno, K. J. (2005). A prospective observational study of domestic violence during pregnancy. *Obstetrics and Gynecology, 106*(1), 61-65.

Zeitler, M., Paine, A., Breitbart, V., Rickert, V., Olson, C., Stevens, L., Rottenberg, L., & Davidson, L. (2005). Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *Journal of Adolescent Health, 39*(1), 119.e1-119.e8.

Zlotnick, C., Capezza, N. M., & Parker, D. (2011). An interpersonally based intervention for low-income pregnant women with intimate partner violence: A pilot study. *Archives of Women's Mental Health, 14*(1), 55-65.

LIST OF CONTRIBUTORS

Below are the names of individuals and federal agencies that contributed to the development of this toolkit.

Federal Agencies:

- Administration for Children and Families
- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention
- Health Resources and Services Administration
- Indian Health Service
- National Institutes of Health
- Substance Abuse and Mental Health Services Administration

Non Federal Agency Contributors:

- Avril Albaugh, LISW
  Cleveland Regional Perinatal Network, University Hospitals Case Medical Center
- Jacquelyn C. Campbell, PhD, RN, FAAN
  Johns Hopkins University School of Nursing
- Lucy Candib, MD
  University of Massachusetts Medical School
- Diana Cheng, MD, MPH, FCOG
  Maryland Department of Health and Mental Hygiene
- Stacey D. Cunningham, MSW, MPH
  National Healthy Start Association, Inc.
- Graciela Gonzalez
- Millie Jones
  Wisconsin Department of Health Services
- Michelle LaRue, MD
  National Alliance for Hispanic Health
- Rachel Locker, MD
  Warms Springs Wellness Center, Oregon
- Rebecca Levenson
  Futures Without Violence
- Jeanne Mahoney
  American Congress of Obstetricians and Gynecologists
- Rhonda Mattox, MD
  University of California, Los Angeles
- Linda G. Mills, JD, MSW, PhD
  New York University
- Denise Morris
  First Alaskans Institute
- Lauren Raskin Ramos, MPH
  Association of Maternal and Child Health Programs
- Michael A. Rodríguez, MD, MPH
  University of California, Los Angeles
- Audrey F. Saftlas, MPH, PhD
  University of Iowa College of Public Health
- Suganya Sockalingam, PhD
  Change Matrix LLC
- Denese Shervington, MD, MPH
- Jeanette Valentine, PhD
  Pathways
- Carole Warshaw, MD
  National Center on Domestic Violence Trauma and Mental Health
- Shelby Weeks, MHS
  North Carolina Healthy Start Project
- Linda Weinreb, MD
  UMass Memorial Health Care
- Connie Gayle White MD, MS, FACOG
- Gloria Aponte Clarke, MPH
  Altarum Institute
- Jenny Namur Karp, MPH
  Social Solutions International, Inc.
- Kristen Stier, MA
  Social Solutions International, Inc.

U.S. Department of Health and Human Services
Health Resources and Services Administration